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ABSTRACT

This manual presents information about the disease, Acquired Immune Deficiency Syndrome (AIDS), and guidelines for service delivery to Montana residents who have been diagnosed with AIDS or related disorders. The first section describes the disease's causes, symptoms, and transmission; risk factors; high-risk populations; prevention suggestions; and diagnosis and treatment. Section II presents guidelines for health care workers and health care facilities, covering such areas as personnel management, hospitals, out-patient services, home health care, dentists and dental care personnel, and optometrists and ophthalmologists. The third section presents guidelines for personal service workers and facilities, including food service establishments, public accommodations, and swimming pools. Section IV considers guidelines for custodial institutions. Guidelines for schools and day care centers, covering such areas as school attendance guidelines, general precautions, personal contact, contact with blood or other body fluids, soiled items, and employees with AIDS are discussed in Section V. Section VI lists reporting requirements and guidelines for confidentiality and public relations. Section VII lists resources for further information, including addresses of five organizations with information on AIDS; and a bibliography. Among appendices are suggestions for blood and body fluid precautions; an AIDS Personnel Exposure Report Form; a guide to chemical agents for disinfection and sterilization; a form for reporting sexually transmitted diseases; and the Montana Code for confidentiality of health care information. (CB)

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AIDS

Acquired Immune Deficiency Syndrome

Information and Procedural Guidelines for Providing Services to Persons With AIDS/HTLV-III

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CONTENTS

	Page
Acknowledgments	i
Introduction	i
SECTION I -- ACQUIRED IMMUNE DEFICIENCY SYNDROME	I-1
Questions and Answers About AIDS and HTLV-III/LAV	I-2
What Is AIDS?	I-2
What Causes AIDS?	I-2
What Are Its Symptoms?	I-2
Who Is Being Affected?	I-3
How is AIDS Transmitted?	I-4
What Are Some of the Diseases Affecting Persons with AIDS?	I-4
What Risk Factors Have Been Identified?	I-5
Why are Homosexual Men At High Risk For AIDS?	I-5
Why Are IV Drug Users at Higher Risk For AIDS?	I-5
What is Recommended to Individuals at Risk to Prevent Further Spread of AIDS?	I-6
How Contagious is AIDS?	I-7
How Is AIDS Diagnosed?	I-8
What Laboratory Tests are Available for HTLV-III?	I-9
What Should Be Considered Prior to Antibody Testing?	I-10
What Are Some Considerations in the Medical Evaluation of Someone With A Reactive Test?	I-10
Can AIDS Be Cured?	I-10
What Is Being Done to Halt the Spread of AIDS?	I-10
SECTION II -- GUIDELINES FOR HEALTH CARE WORKERS AND HEALTH CARE FACILITIES	II-1
Personnel Management	II-2

Overview II-2
Considerations in Patient Care Assignments II-2
Accidental Exposure to AIDS/HTLV-III II-3
Employees With AIDS/HTLV-III II-5
Other Issues in the Workplace II-6
Hospitals II-8
Out Patient Services II-12
Laboratories II-13
Long-Term Care Facilities II-15
Home Health Care II-16
Dentists and Dental Care Personnel II-17
Pre-Hospital Emergency Health Care II-21
Morticians' Services/Necropsies II-25
Optometrists/Ophthalmologists II-27

SECTION III -- GUIDELINES FOR PERSONAL SERVICE WORKERS AND FACILITIES/AGENCIES III-1
Personal Service Workers III-2
Overview III-2
Personnel Practices III-2
Food Service Establishments III-4
Public Accommodations III-5
Swimming Pools III-6

SECTION IV -- GUIDELINES FOR INSTITUTIONS IV-1
Custodial Institutions IV-2

SECTION V -- GUIDELINES FOR SCHOOLS AND DAY CARE CENTERS V-1
Background V-2

School Attendance Guidelines V-2

General Precautions V-3

Personal Contact V-3

Contact With Blood or Other Body Fluids V-4

Soiled Items V-4

Employees with AIDS/HTLV-III V-4

Other Issues in the Workplace V-5

ALTERING CHILD CARE PRACTICES WHEN A CHILD HAS AIDS/HTLV-III V-6

SECTION VI -- REPORTING REQUIREMENTS, CONFIDENTIALITY AND PUBLIC RELATIONS VI-1

SECTION VII -- RESOURCES FOR FURTHER INFORMATION VII-1

Montana AIDS Task Force VII-2

Information Resources VII-3

HTLV-III Antibody Test Sites VII-4

Bibliography VII-5

SECTION VIII -- APPENDICES VIII-1

A. Revision of the Case Definition of AIDS for National Reporting -- United States VIII-2

B. Provisional Case Definition of AIDS in Children, CDC . . . VIII-2

C. Blood/Body Fluid Precautions VIII-5

D. AIDS Personnel Exposure Report Form VIII-7

E. Personnel Exposure Follow-up Form VIII-11

F. Guide to Chemical Agents for Disinfection and/or Sterilization VIII-14

G. Disinfectant Characteristics of Iodophors VIII-15

H. MSDHES Sexually Transmitted Disease Program HTLV-III Test Report VIII-16

I. MCA 50-16-301 through 314: Confidentiality of Health Care Information VIII-17

J. Emergency Amendment of Rules: ARM, 16.28.201 and 16.28.202 Regarding AIDS and HTLV-III VIII-20

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INTRODUCTION

As of December 16, 1985, 15,581 persons in the United States have been diagnosed as having the disease known as Acquired Immune Deficiency Syndrome (AIDS); 8,200 of these persons, or more than 50% have died. At this time, cases appear to be doubling every ten to twelve months nationally. The State of Montana confirmed its first case of AIDS in October, 1985.

At this time, AIDS has a high fatality rate. Survival time following diagnosis is dependent upon the length of time a person has had the syndrome and what specific opportunistic diseases have occurred. The fact that this disease occurs in specified high risk groups and is fatal has led to a great deal of public fear and concern about the contagiousness of this disease.

Many persons in high-risk groups develop chronic, non-specific symptoms which have been referred to as AIDS-related complex or condition (ARC). While many of the ARC patients do not go on to develop frank AIDS, ARC is caused by the same retrovirus that causes AIDS. Within this document, recommendations and guidelines directed at persons with AIDS also apply to those persons with ARC. Recommendations and guidelines for persons with positive antibody reactions to HTLV-III/LAV* testing are also included.

It is the posture of the Montana Department of Health and Environmental Sciences (DHES) that the health care community, as well as the public at large, needs to be informed of the current findings about this disease. To the extent practicable, DHES recommends that persons with AIDS be treated in regular health care settings and considered for normal placement alternatives, appropriate for their overall health and social circumstances.

In this document, DHES has condensed available information on AIDS/HTLV-III, and has established guidelines designed to improve service delivery to persons who have been diagnosed with AIDS or related disorders. At the same time, precautions to protect the care-givers are presented, as are reporting requirements relative to AIDS and HTLV-III antibody testing. This document is also intended as an informational tool for the public.

As additional information about AIDS and its management becomes available, this document will be updated.

*Throughout this document HTLV-III will be used.

SECTION I

ACQUIRED IMMUNE DEFICIENCY SYNDROME

QUESTIONS AND ANSWERS ABOUT AIDS AND HTLV-III/LAV*

These questions and answers present current information about the nature and extent of AIDS, testing available for antibodies to the "AIDS virus" -- HTLV-III/LAV*, the risk of contracting AIDS, the actions individuals can take to reduce spreading AIDS, and current research and related activities under way.

WHAT IS AIDS?

AIDS stands for "acquired immune deficiency syndrome," a recently recognized condition characterized by a defect in natural immunity against disease. People who have AIDS are vulnerable to serious illnesses which would not be a threat to anyone whose immune system was functioning normally. These illnesses are referred to as "opportunistic" infections or diseases.

ACQUIRED -- means the disease is not inherited or genetic, but is one which is developed later.

IMMUNE -- refers to the body's natural system of protecting itself from disease or fighting infection.

DEFICIENCY -- means the immune system is not working and therefore not protecting the body from disease.

SYNDROME -- means a group of signs or symptoms that occur together.

WHAT CAUSES AIDS?

Medical researchers have discovered AIDS is caused by a virus known as HTLV-III (Human T-Lymphotropic Virus type III); lymphadenopathy associated virus (LAV); or AIDS related virus (ARV). Infection with this virus does not always lead to AIDS.

WHAT ARE ITS SYMPTOMS?

Most individuals infected with the AIDS virus have no symptoms and feel well. Some develop symptoms which are similar to many common viral illnesses, such as flu, bronchitis, and colds. HOWEVER, with AIDS the symptoms are generally unexplained, last for a longer period of time, and tend to recur.

These symptoms can occur over a period of months before a specific disease such as Kaposi's sarcoma or Pneumocystis pneumonia is diagnosed. Each of these symptoms listed below can appear in illnesses that are not associated with AIDS.

*Throughout this document HTLV-III will be used.

For example, everyone occasionally experiences tiredness, headaches, fevers and diarrhea.

Individuals at high-risk may exhibit the following symptoms:

-- Extreme tiredness, sometimes combined with headaches, dizziness or light-headedness;

-- Continued fever or night sweats;

-- Weight loss of more than 10 pounds which is not due to dieting or increased physical activity;

-- Persistent enlarged lymph nodes (swollen glands) in the neck, arm pits, groin or other sites;

-- Purple or discolored growths on the skin or the mucous membrane (inside the mouth, anus or nasal passages);

-- Heavy, continual dry cough that has lasted too long to be due to a cold or flu;

-- Continuing bouts of diarrhea;

-- Thrush, a thick, whitish coating on the tongue or in the throat which may be accompanied by sore throat;

-- Unexplained bleeding from any body opening or from a growth on the skin or mucous membranes;

-- Bruising which occurs more easily than usual;

-- Progressive shortness of breath.

Anyone with symptoms which continue for more than two weeks should see a doctor.

The time between infection with the HTLV-III virus and the onset of symptoms (incubation period) seems to range from about 5 months to 5 years and possibly longer. Not everyone exposed to the virus develops AIDS.

WHO IS BEING AFFECTED?

As of December 16, 1985, 15,581 people have developed AIDS in the United States. Ninety-four percent of the AIDS cases in the U.S. have occurred in the following groups of people:

-- Sexually active homosexual and bisexual men with multiple partners, 73%;

-- Present or past users of intravenous drugs, 17%;

-- Persons with hemophilia or other coagulation disorders, 1%;

-- Heterosexual contacts of someone with AIDS or at risk for AIDS, 1%;

-- Persons who have had transfusions with blood or blood products, 2%.

Some 6% of cases do not fall into any of these groups, although researchers believe transmission occurred in similar ways. Infants and children who have developed AIDS may have been exposed to HTLV-III before or during birth, or shortly thereafter, or may have a history of transfusions.

As of December 16, 1985 226 cases of AIDS have been reported in children under 13 years of age who do not appear to have either an inherited immune deficiency or other serious underlying illness such as leukemia.

About 90% of persons with AIDS are between 20 and 49 years of age, with males accounting for 92% of all cases. All races have been affected.

HOW IS AIDS TRANSMITTED?

AIDS is spread by direct intimate sexual contact, through the use of shared needles for injection of drugs, and less commonly from blood products. The risk of getting AIDS is increased by having multiple sexual partners, either homosexual or heterosexual. AIDS may be transmitted from an infected mother to her infant before, during or shortly after birth.

WHAT ARE SOME OF THE DISEASES AFFECTING PERSONS WITH AIDS?

Many people with AIDS have had one or both of two rare diseases: (1) Kaposi's sarcoma (KS), a type of cancer; and (2) Pneumocystis carinii pneumonia (PCP), a parasitic infection of the lungs. These and some other opportunistic infections (OOI) seen in AIDS patients are described below:

Kaposi's Sarcoma is a cancer of the tissues beneath the skin and the mucous secreting surfaces of the digestive tract, the lymph nodes and the lungs. KS lesions are often first noticed as bluish to reddish discolorations or raised, firm, purple spots on arms, legs or feet. These lesions can also appear in the mouth. The lesions neither itch nor are they painful.

Pneumocystis Carinii Pneumonia is a pneumonia caused by a protozoan (not a bacterium or a virus). It is difficult to treat and may be life threatening. Common symptoms of PCP are persistent, prolonged cough; shortness of breath; and fever.

On physical examination, common findings include rales, rhonchi (abnormal sounds in lungs); and diffuse intersitial infiltrate on chest x-ray (may be normal or only mildly abnormal).

Cryptococcosis is caused by a fungus that can infect the brain, lungs, liver, intestinal tract and skin. Severe disseminated cases are associated with AIDS.

Non-Hodgkins Lymphoma is a cancer of the lymph nodes that is now being reported at a greater than expected frequency among immunodeficient homosexual men. Primary lymphoma of the brain is one diagnosis indicative of AIDS.

Candidiasis is a yeast infection that takes advantage of the immune deficiency state and can cause overwhelming and sometimes difficult to treat

infections of the digestive tract. In the AIDS patient, candidiasis often causes an inflammation of the esophagus.

Herpes Simplex is a virus that frequently causes localized and short-lived "fever blisters" or eruptions on the skin of the face, buttocks, anus or genitals. In immunodeficient individuals, herpes can produce severe and prolonged lesions that cover large areas of the body lasting more than one month.

Cytomegalovirus (CMV) is a virus that usually produces symptoms similar to infectious mononucleosis, or may produce no overt symptoms whatsoever. In the immunodeficient individual, CMV can lead to serious and debilitating infections including pneumonia.

Toxoplasmosis is a parasitic infection that rarely affects normal persons but in immunodeficient persons may become a severe disseminated disease with fever, rash, enlarged liver, spleen and lymph nodes. Headache, fever, confusion and seizures occur with central nervous system disease, often followed by death.

Cryptosporidiosis is a protozoal infection causing chronic, persistent diarrhea (longer than 1 month).

WHAT RISK FACTORS HAVE BEEN IDENTIFIED?

AIDS does not appear to be a threat to the general public. Of the groups considered "high risk," not all members are at equal risk. Studies of persons with AIDS indicate the following people are at known risk of exposure to HTLV-III:

-- Gay and bisexual men with multiple partners;

-- IV drug users who share needles;

-- Recipients of certain blood products;

-- Sexual partners of someone who has AIDS or a known HTLV-III related condition or infection, or who is in one of the above groups;

-- Infants born to mothers at risk for AIDS.

Other risk factors have not yet been identified.

WHY ARE HOMOSEXUAL MEN AT HIGH RISK FOR AIDS?

Homosexual men who have intimate sexual contact with a large number of partners increase the possibility of coming into contact with infected individuals. Homosexual acts themselves are likely to provide the route of transmission, because they may cause injury to the lining of the rectum and mouth.

WHY ARE IV DRUG USERS AT HIGHER RISK FOR AIDS?

The higher risk for intravenous drug users is almost certainly due to sharing or reusing unclean needles when injecting the drugs, since blood from a person with

AIDS may contain the virus and be injected into the blood stream of a healthy person.

WHAT IS RECOMMENDED TO INDIVIDUALS AT RISK TO PREVENT FURTHER SPREAD OF AIDS?

An individual judged most likely to have an HTLV-III infection should be provided the following information and advice:

-- The prognosis for an individual infected with HTLV-III over the long term is not known. However, data available from studies conducted among homosexual men indicate that most persons will remain infected.

-- Although asymptomatic, these individuals may transmit HTLV-III to others. Regular medical evaluation and follow-up is advised, especially for individuals who develop signs or symptoms suggestive of AIDS.

-- There is a risk of infecting others by sexual intercourse, sharing of needles, and possibly, exposure of others to saliva through oral-genital contact or intimate kissing. The effectiveness of condoms in preventing infection with HTLV-III is not proven, but their consistent use may reduce transmission, and should be promoted strongly among all persons at risk.

-- Persons who are increased risk for having AIDS -- or who have positive blood tests -- should not donate blood or plasma, organs or tissues or sperm.

-- Don't use IV drugs. If you use IV drugs, then don't share needles or syringes.

-- Don't use inhalent nitrites (poppers).

-- Avoid close contact with individuals who have flu, colds or other known communicable diseases.

-- Eat a balanced diet, making sure all meats, poultry and fish are well-cooked, and vegetables thoroughly washed. While this is sound advice for anyone, it is especially true for AIDS patients in order to help reduce the potential risk from other infections.

-- Avoid recreational drug use, including excessive use of alcohol.

-- Don't have any immunizations without first telling the health care provider you have AIDS. Living viruses found in some vaccines could be harmful to immune deficient patients.

-- Avoid casual use of antibiotics. Take them only when your physician, aware that you have AIDS, directs you to. Inappropriate use of antibiotics could lead to infection with resistant organisms.

-- If your doctor tells you that your platelet count is low, avoid aspirin, as it may aggravate bleeding.

-- Toothbrushes, razors, or other implements that could become contaminated with blood should not be shared.

-- Women who are reactive or whose sexual partners are antibody-positive are themselves at increased risk of acquiring AIDS. If these women become pregnant, their children are also at increased risk of acquiring AIDS.

-- Contact with family and friends can be normal; hugging and kissing on the cheek do not spread the virus.

-- Contact with people at work or in the community should be as usual. Special precautions and restrictions are not necessary.

-- Avoid exposure to animal wastes because of other diseases which may be carried by these wastes. Wear gloves when cleaning up after pets. If your cat or other pets appear to be ill, have them checked immediately. Avoid contact with puppies, kittens and waste-laden bird roosts.

-- Clean minor injuries (e.g., cuts and scrapes) with soap and water. If they don't heal quickly, see a physician.

-- Children born since 1979 to women with a reactive HTLV-III test should be clinically evaluated.

-- Devices that have punctured the skin, such as hypodermic and acupuncture needles, should be steam sterilized by autoclave before reuse or safely discarded. Whenever possible, disposable needles and equipment should be used.

-- When seeking medical or dental care for intercurrent illness, persons with reactive tests should inform those responsible for their care of their positive antibody status so that appropriate evaluation can be undertaken and precautions taken to prevent transmission to others.

-- Testing for HTLV-III antibody should be considered for persons who may have been infected as a result of their contact with reactive persons (e.g., sexual partners, persons with whom needles have been shared, infants born to reactive mothers). Other household contacts need not be referred for testing at this time.

-- When employed in medical, dental or other health care related fields, persons with reactive tests should take precautions similar to those recommended for hepatitis B to protect their patients from the risk of infection.

-- Most individuals with reactive HTLV-III results and in a high risk group need <u>not</u> consider a change in employment. However, those persons whose work involves significant potential of exposing others to his or her blood or other body fluids should, at a minimum, be advised to act prudently and take precautions such as wearing gloves.

<u>HOW CONTAGIOUS IS AIDS?</u>

<u>Healthy persons not belonging to high risk groups should not fear infection with AIDS</u>. Casual contact with members of risk groups, persons incubating AIDS or even persons under treatment for AIDS has not been shown to cause infection. Living in the same house, riding the same public transportation, eating in the

same public places, sitting on a toilet seat, working in the same office, and being around a person with AIDS are not recognized risks of infection to healthy individuals in the general population.

> ". . . For men or women in the U.S. who are straight, who don't take drugs intravenously, and who aren't hemophiliacs requiring transfusions, the chances of contracting AIDS are less than one in a million. (The chances of dying in a car accident are about one in 5,000; of being murdered, one in 10,000; and of being struck by lightning, one in 600,000.). . ."
>
> John Langone
> DISCOVER, December 1985
> Page 31

Although the AIDS virus has been found in saliva and tears, there have been no cases in which exposure to either was shown to result in transmission. Ambulance drivers, police and fire fighters who have assisted AIDS patients have not become ill.

No case of AIDS has been reported among nurses, doctors, and health care personnel as a result of caring for AIDS patients. However, several health care workers with needle stick injuries have become positive when tested for HTLV-III antibodies. Health care and laboratory workers should follow safety procedures when handling blood and tissue samples from patients with potentially transmissible diseases, including AIDS. Extreme caution should be used when handling or disposing of hypodermic needles. In fact, AIDS patients are at much greater risk of developing infections from normal, healthy persons than of transmitting infection to normal, healthy persons.

HOW IS AIDS DIAGNOSED?

There are no clear-cut symptoms that indicate the loss of immunity. The diagnosis of AIDS depends on the presence of opportunistic diseases. Certain tests which demonstrate damage to various parts of the immune system, such as specific types of white blood cells, support the diagnosis.

The specific immune defect in AIDS has not been identified, but many patients show a decrease in the number of certain white blood cells called T-helper lymphocytes. Although the function of these cells can be measured, these tests are not sensitive or specific enough to be used routinely. Moreover, other illnesses can cause this test to be abnormal.

The presence of opportunistic disease plus a positive test for antibodies to HTLV-III can make possible a clinical diagnosis of AIDS.

The Centers for Disease Control (CDC) defines a case of AIDS as a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease. Such diseases include KS, PCP, and serious OOI.[§] Diagnoses are considered to fit the case definition only if based on sufficiently reliable methods (generally histology or culture. The revision and update of this case definition appears as Appendix A.

WHAT LABORATORY TESTS ARE AVAILABLE FOR HTLV-III?

Tests to detect antibodies to HTLV-III have been licensed and are commercially available in the United States. The first licensed antibody tests are modifications of the enzyme-linked immunosorbent assay (ELISA), which uses antigens derived from whole disrupted HTLV-III. The primary use of the antibody tests is to screen blood and plasma to eliminate from the blood supply those units which may contain this virus.

Currently available ELISA tests can be expected to identify most persons with HTLV-III infection. The tests are NOT tests for AIDS. They only detect antibody against the HTLV-III virus. They do not determine if the virus is still present; they do not predict if a person will become ill from the virus infection; nor do they indicate immunity.

HTLV-III has been isolated from blood, semen, saliva and tears, and has been recovered from many individuals who have antibodies. Blood and semen have been implicated in transmission to date.

HTLV-III has been isolated from the blood of 85 percent or more of seropositive individuals with AIDS, lymphadenopathy or other AIDS-related conditions, and from three of four mothers of infants with AIDS. The virus also has been isolated from asymptomatic seropositive homosexual men and hemophiliacs, and has been recovered from 95 percent of seropositive, high-risk blood donors who had been implicated in the transmission of AIDS through transfusion.

[§]These infections include pneumonia, meningitis, or encephalitis dur to one or more of the following aspergillosis, candidiasis, cryptococcosis, cytomegalovirus, nocardiosis, strongyloidosis, toxoplasmosis, zygomycosis, or atypical mycobacteriosis (species other than tuberculosis or lepra); esophagitis due to candidiasis, cytomegalovirus, or herpes simplex virus; progressive multifocal leukoencephalopathy; chronic enterocolitis (more than 4 weeks) due to cryptosporidiosis; or unusually extensive mucocutaneous herpes simplex of more than 5 weeks duration.

WHAT SHOULD BE CONSIDERED PRIOR TO ANTIBODY TESTING?

People with HTLV-III antibody may also be infected with the virus and may transmit it to others. Since a diagnosis of AIDS or of infection with HTLV-III may create considerable anxiety and stress, it is important that each person understand the implications of the antibody test before being tested and be given the opportunity to decline to be tested.

Blood banks may also defer donors with reactive HTLV-III antibody tests for post-test counseling and follow-up evaluation. Clinical laboratories may acquire the antibody test kits and need to understand the appropriate use for, and implications of the test.

Specifically, people inquiring about antibody testing should know the following:

1. They are being tested for the antibodies to HTLV-III virus which is the cause of AIDS.

2. The HTLV-III antibody test is not a diagnostic test for AIDS.

3. As with any test, false positives and false negatives may occur; i.e., in a given person, the test results may be further evaluated to determine whether he/she has been infected.

4. Disclosure of test results could result in unwarranted discrimination in employment and insurance.

5. Persons need to make arrangements as to when and how they will be notified if their test is reactive.

Physicians and other health personnel must recognize the need to maintain confidentiality about reactive test results. Disclosure of this information for purposes other than medical or public health could lead to serious and unwarranted consequences for an individual with a reactive blood test. Screening procedures should be designed with safeguards to protect against unauthorized disclosures. Donors should be given a clear explanation of how information about the results of the test will be handled. Facilities should consider developing contingency plans in the event that disclosure is sought through legal process.

WHAT ARE SOME CONSIDERATIONS IN THE MEDICAL EVALUATION OF SOMEONE WITH A REACTIVE TEST?

If a patient is referred to a physician with a reactive test for HTLV-III, the patient should be questioned about possible exposure to the virus or possible risk factors for AIDS such as sexual orientation, history of IV drug use, hemophilia, recent history of transfusion of blood or blood products, and sexual contact with members of high-risk groups. A second ELISA test should be obtained on a follow-up serum if not already done and, if reactive, another antibody test may be performed on persons who do not appear to belong to any known AIDS risk group. A person who continues to show serologic evidence of HTLV-III infection should be questioned about the number and health of sexual partners, and whether he or she has had sexual contact with persons in AIDS high-risk groups.

The patient should be examined for signs of AIDS-related conditions. Testing for antibodies to HTLV-III in the individual's sexual partners may also be useful in establishing whether the test results represent true infection.

CAN AIDS BE CURED?

At the present time, there is no known treatment that can restore the body's immune system to normal once it has been damaged by AIDS. Treatment can be given for the various diseases and infections that attack AIDS patients. However, since the immune system remains damaged, a person with AIDS will continue to be at risk of other serious infections and cancers. The opportunistic cancers and infections may be treated individually with varying success. Many immunologic therapies are being attempted but have not been completely evaluated. There is currently no vaccine, serum, or medicine which can protect someone from developing AIDS.

Survival time following diagnosis is dependent upon the length of time the patient has had the syndrome and what specific opportunistic diseases have occurred. Thus, barring any breakthroughs in treatment, at least 50% of AIDS patients can be expected to die within 18 months of diagnosis and some 80% can be expected to die within 36 months of diagnosis, with the prognosis slightly better in those who have only Kaposi's sarcoma.

WHAT IS BEING DONE TO HALT THE SPREAD OF AIDS?

The Centers for Disease Control (CDC) formed a task force in July 1981 to investigate the problem and seek methods of prevention and control. Workers on the task force include physicians, public health advisors, epidemiologists, statisticians, laboratory scientists, and others, both at CDC headquarters in Atlanta, Georgia, and at state and local health departments across the country. Numerous medical schools and research institutes are also carrying out studies. In addition, a nationwide educational effort has been made to inform persons in high-risk groups about AIDS, with special emphasis on "safe sex" practices.

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SECTION II

GUIDELINES FOR HEALTH CARE WORKERS AND HEALTH CARE FACILITIES

PERSONNEL MANAGEMENT

OVERVIEW

As with any serious disease whose etiology is not completely understood, acquired immune deficiency syndrome (AIDS) is currently causing considerable concern throughout the United States. Stories about individual cases and about research progress in unraveling the etiology and control of AIDS appear in the news media almost daily. This concern is understandable and is an increasingly important issue among health care personnel, who in the course of their duties may care for patients with AIDS.

Precautions for health professionals who work with AIDS patients are designed to minimize the risk of mucosal or parenteral exposure to potentially infective materials. Such exposure can occur during direct patient care, while working with laboratory specimens, or from inadvertent or unknowing exposure to equipment, such as needles contaminated with potentially infective materials.

In addition to being informed of these precautions, all health care workers, including students and house staff should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

The purpose of the following guidelines is to prevent spread of presumably transmissible agents to others and to protect patients with AIDS from the acquisition of opportunistic infections. The guidelines should be followed at any time blood or body fluids are handled to reduce the risk of infection by agents other than the HTLV-III virus, as well. Persons may be infectious with some organisms before any symptoms appear.

Recommendations for personnel involved in invasive procedures are being developed by the Centers for Disease Control.

CONSIDERATIONS IN PATIENT CARE ASSIGNMENTS

Some health care personnel have been reluctant to provide hands-on care to AIDS patients. However, at this time there is no evidence that the risks in doing so are any greater than the risk associated with caring for any other sick persons. Accordingly, personnel should not be excused on their own request from delivering care to AIDS patients. There is no scientific or ethical reason to do so. If an employee having direct care responsibility refuses to perform his or her duties in relation to caring for AIDS patients, the issue becomes an administrative problem to be resolved on an individual basis. Institutions are urged to solicit the advice of their own personnel officers/managers in such situations.

Suggested steps for employees with direct patient care responsibility are:

1. Employees should be fully briefed regarding their direct care responsibilities (as outlined in their official position descriptions) prior to the arrival of patients with AIDS. Employees who voice objections should be provided individual counseling by supervisory personnel to further explain that the risk of exposure is minimal, and to outline precautions being taken. It is to be expected that certain employees may seek reassignment

to other units. On the other hand, some dedicated employees may volunteer for the assignment.

2. An employee who actually refuses to perform required work must be dealt with promptly since any delay in management taking action would possibly encourage other employees to also be insubordinate.

3. Employees who believe they are at high risk for infection because of their own immune status should be encouraged to discuss their work responsibilities with their personal physicians. If the physician determines that there are certain assignments the employee should not accept, this should be communicated in writing to the employer. Caretakers should be in good health, free of symptoms such as fever, diarrhea, etc., so they will not be a possible source of infection to the patient.

4. Personnel with certain high risk illnesses should not be assigned to work with AIDS patients who have easily transmissible opportunistic infections (e.g., CMV, varicella-zoster, etc.). The following are examples of personnel in high risk categories:

    1) Persons presently or frequently receiving large dose steroid drugs on a daily basis sufficient to depress the immune function (more than 1 mg/kg prednisone per day, e.g., some asthmatics);

    2) Persons with known immune deficiency diseases (e.g., Lupus Erythematosus, Agammaglobulinemia, Hodgkins Disease);

    3) Persons receiving or who recently have received chemotherapy and have not achieved immune or hematologic recovery.

    4) Persons receiving any immunosuppressive medications;

    5) Pregnant women should be assessed for risk of exposure to the opportunistic infections of patients with AIDS, and need to avoid persons who are shedding CMV, especially if the shedders are being treated with high speed instrumentation that creates spatter, aerosols, and mist.

ACCIDENTAL EXPOSURE TO AIDS/HTLV-III

Care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infective material and to avoid contact of mucous membranes and open skin lesions with materials from patients. Parenteral injections and blood drawing should be kept to a minimum and carried out by experienced personnel.

Employees who have needle-stick or other injuries associated with the care of AIDS patients should be reported to their employee health service and ongoing records should be maintained (see Appendix D & E for sample forms).

Parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure or a health care worker to blood or other body fluids requires the source patient be assessed clinically and epidemiologically to determine the likelihood of HTLV-III infection. If the assessment suggests that

infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III infection. If the source patient has AIDS or other evidence of HTLV-III infection, declines testing, or has a positive test, the health care worker should be evaluated clinically and serologically for evidence of HTLV-III infection as soon as possible after the exposure, and if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed health care workers should receive counseling about the risk of infection and following recommendations for preventing transmission of AIDS. If the source patient is seronegative and has no other evidence of HTLV-III infection, no further follow-up of the health care worker is necessary.

1. Accidental exposure to AIDS/HTLV-III may occur in ways similar to accidental exposure to hepatitis B -- blood or any body secretion or excretion from an infected patient:

   a. entering the body by needle puncture wound, scalpel cut, via skin perforation; e.g., human bite.

   b. entry via contact with any mucous membrane surface such as the eye, nose or mouth.

   c. entry via an existing open cut, scratch, hangnail or other broken skin barrier (eczema).

2. Treatment of Exposure to AIDS -- IMMEDIATELY. . . follow the guidelines below.

   For wounds not requiring sutures, the following is recommended. Generally, wounds more than six hours old should not be sutured, as the risk of infection increases with time.

   a. Vigorously scrub the wound with soap and water and copiously irrigate with water.

   b. Cover the wound with a loose bandage that will keep out dirt and protect the wound from trauma.

   c. Tetanus immunization status should be determined, using the guidelines in Table 1.

Table 1
Guide to Tetanus Prophylaxis in Routine Wound Management -- United States, 1985

History of Absorbed Tetanus Toxoid (doses)	Clean, Minor Wounds		All Other Wounds[†]	
	Td[§]	TIG	Td[§]	TIG
Unknown or Three	Yes	No	Yes	Yes
Three[¶]	No**	No	No[++]	No

[†]Such as, but not limited to, wounds contaminated with dirt, feces, soil, saliva, etc; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns and frostbite.

[§]For children under 7 years old; DTP (DT, if pertussis vaccine is contraindicated) is preferred to tetanus toxoid alone. For persons 7 years old and older, Td is preferred to tetanus toxoid alone.

[¶]If only three doses of fluid toxoid have been received, a fourth dose of toxoid, preferably an absorbed toxoid should be given.

**Yes, if more than 10 years since last dose.

[++]Yes, if more than 5 years since last dose. (More frequent boosters are not needed and can accentuate side effects.)

d. Consult with employee health service, private physician, and infection control personnel as indicated or per policy of facility.

3. Follow protocol for exposure to hepatitis B. (Blood/Body Fluid Precautions, Appendix C.)

4. It is very important to evaluate the possible risk of AIDS transmission after such accidental exposures. The Centers for Disease Control (CDC) Hospital Infections Program has initiated an active surveillance system to evaluate and follow-up health care personnel who have documented parenteral or mucous membrane exposure to persons reactive to HTLV-III. Infection control personnel who have been notified of these types of accidental exposures in their institutions should contact the CDC Hospital Infections Program, (404) 329-3406. (See Appendix D and E for sample forms.)

EMPLOYEES WITH AIDS/HTLV-III

Employees who have AIDS and are directly involved in patient care require special consideration. Their continued contact with patients raises concern about the potential spread of infectious diseases to them from infected patients and vice-versa. The direct transmission of AIDS itself to patients appears to

be unlikely as there is to date no evidence supporting casual contagion. Employees with AIDS may have an undiagnosed transmissible infection such as CMV or Pneumocystis and may thus represent a small but real risk to patients who might themselves be immunosuppressed. An equally important problem is the potential for transmission of unsuspected and undiagnosed infections from patients to the employee with AIDS. Employees with AIDS/HTLV-III who carry out intimate or invasive patient care procedures may merit special concern.

As with any employee with an active illness, when an AIDS employee is symptomatic, he should not be directly involved in patient care since illness may interfere with the employee's ability to function competently. HTLV-III positive employees within health care facilities could be approached in two different ways:

1. A positive HTLV-III employee could be reassigned to a non-patient care position in order to protect the employee from nosocomial pathogens and protect high-risk patients from pathogens possibly carried by the employee.

2. The employing facility should consider each reactive HTLV-III employee on a case by case basis, through their employee health service in conjunction with recommendations from the employee's private physician, to determine that 1) the employee is free from transmissible infection, ?) the employee is not unduly susceptible to infections he might come in contact with in the line of performing his patient care duties. Patient care responsibilities could then be assigned according to an ongoing clinical evaluation of the employee's status.

3. Similar considerations apply to physicians with positive HTLV-III. The medical staff structure must be prepared to monitor and to deal with the possibility of excluding physicians from the institution should it become apparent there may be significant risks to either the physician or to patients.

Institutions who have employees or physicians with reactive HTLV-III tests are urged to solicit advice from their legal counsel and the state epidemiologist, (406) 444-4740.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III infection. The diagnosis of HTLV-III infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws covering occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

References

CDC, "Adult Immunization: Recommendations of the Immunization Practices Advisory Committee (ACIP)," 1985, p. 515.

CDC, "Guidelines for Prevention of Surgical Wound Infections, 1985," U.S. Government Printing Office.

CDC, "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace," MMWR, Volume 34, No. 45, November 15, 1985.

HOSPITALS

GENERAL APPROACH

Procedures should be consistent with Blood/Body Fluid Precautions (see Appendix C) which include the use of gloves and hand-washing when in contact with patient's blood or secretions. Gowns are recommended for those likely to have direct contact with the patient's secretions and blood.

ROOM ASSIGNMENTS/ISOLATION LEVEL

Strict isolation rooms are not necessary for AIDS patients; however, it may be prudent to place AIDS patients in private rooms. This is not essential if the patient is not coughing, is cooperative, and can be adequately instructed on blood, body fluids and enteric precautions. It is, however, recommended that, when a double room is used, the additional patient not be an immunocompromised host (e.g., another patient with AIDS) who might be susceptible to the potential opportunistic infections harbored by the patient with AIDS. Additionally, the room mate should not be a patient who might harbor and potentially transmit an infectious agent to the AIDS patient.

AIDS patients should be placed on blood, secretion and excretion precautions. Specimens from patients should be labeled "Blood/Body Fluid Precautions" or other similar designation, without mention of specific disease and placed in an impervious bag or container for transport. Consult forms, x-ray requests, etc., should also be marked to prevent needless exposure in other departments. Patients with AIDS who are being transported require no special precautions other than blood/body fluid precautions. Personnel in the receiving area should be notified of the precautions to be taken.

PROTECTIVE GARMENTS

The following protective garments are recommended:

GLOVES should be worn when personnel are in direct contact with blood, secretions, or excretions of AIDS patients. The gloves may be nonsterile. This recommendation is particularly important for personnel with cuts and abrasions on the hands. Hands should be washed after removing gowns and gloves, and between gloving for other patients.

GOWNS should be worn when clothing may become contaminated with blood, excretions or secretions. Water-protective barrier gowns are recommended when there will be exposure to large volumes of secretions. Plastic aprons may be used instead of gowns.

EYE PROTECTION (e.g, goggles) should be used in situations where splatter with blood, bloody secretions or body fluids is expected (e.g., intubation, bronchoscopy, endoscopy, dental aerosol handpieces).

These protective devices are only necessary when personnel are directly exposed to blood and/or secretions. Such apparel is not necessary if there will only be casual contact while in the patient's room, i.e., visitors.

MASKS are not necessary unless another condition spread via the respiratory route (e.g., tuberculosis) is present. Masks should then be available to all persons who may enter the room. Airborne spread of AIDS has not been shown to occur. Masks are not essential for all AIDS patients, but it is recommended that they be worn by the patient who is actively coughing when out of his room. Masks are advisable for visitors or health care personnel who are in direct, sustained contact with these actively coughing patients. The purpose of this recommendation is to prevent the potential aerosolization of a large inoculum and spread of opportunistic infections (Pneumocystis carinii) to other immunosuppressed patients. This recommendation is based on the theoretical considerations supported by animal studies since this mode of transmission has not been proven in humans. Masks should also be worn by patients in whom Mycobacterium tuberculosis or other agents known to be spread by the droplet or respiratory route have not been ruled out.

CARDIOPULMONARY RESUSCITATION

Keep a bag valve mask/pocket mask and nasal or oral airway in the patient's room for CPR. (See guidelines for Pre-hospital Emergency Health Care, also in this Section.)

EQUIPMENT

The distinction between sterilization and disinfection must be made. Sterilization is the destruction of all microbial forms. Disinfection properly refers only to the inhibition or the destruction of microbial pathogens. Disinfection commonly uses chemical agents and procedures which are unable to destroy microbial spores, mycobacterium tuberculosis, and hepatitis viruses.

1. Sterilization and disinfection procedures currently recommended for use in health care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III.

   Instruments or other nondisposable items that enter normally sterile tissue or the vascular system through which blood flows should be sterilized before reuse.

   Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (including gloves) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

2. All contaminated (visibly soiled with potential infectious material) disposable items are to be considered infectious wastes and must be double-bagged before disposal as per procedures for infectious waste. Nondisposable contaminated items should be bagged and labeled prior to decontamination.

3. Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

LINEN AND DISHES

Laundry and dishwashing cycles commonly used in hospitals and other facilities are adequate to decontaminate linens, dishes, glassware and utensils.

Contaminated linen should be double-bagged until washed in hot water. Bleach should be added to the wash.

Reusable or disposable dishes may be used. Reusable dishes should be machine washed in hot water, or hand washed in plenty of hot, soapy water, followed by thorough rinsing.

ENVIRONMENTAL CLEANSING

Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used in hospitals and other facilities. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves.

Chemical germicides should be registered with and approved by the U.S. Environmental Protection Agency (EPA). Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide. Concentrations ranging from 5,000 ppm (1:10 dilution of household bleach) to 500 ppm (1:100 dilution) are effective dependent upon the amount of organic material (e.g., blood, mucous, etc.) present on the surface to be cleaned and disinfected.

References

CDC, "Acquired Immune Deficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Health Professionals," MMWR, Volume 32, No. 34, September 2, 1983.

CDC, "Guideline for Handwashing and Hospital Environment Control, 1985," U.S. Government Printing Office

CDC, "Guideline for Isolation Precautions in Hospitals," U.S. Government Printing Office.

CDC, "Recommendations for Preventing Transmission of Infection With HTLV-III/LAV in the Workplace: Sterilization, Disinfection, Housekeeping and Waste Disposal to Prevent Transmission of HTLV-III/LAV," MMWR, Volume 34, No. 45, November 15, 1985.

OUTPATIENT SERVICES

The general infection control guidelines used for hospitalized or institutionalized patients should also be applied to the outpatient and emergency setting. Efforts should be made to minimize direct contact to other severely immunocompromised patients. AIDS or HTLV-III outpatients may use common waiting areas and bathroom facilities, unless the presence of other infections require special precautions.

Blood/Body Fluid Precautions as outlined in Appendix C should be observed. Specimen-labeling, equipment sterilization and disposition of equipment should be handled as for hospitalized patients.

L A B O R A T O R I E S

The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious materials. These precautions should be observed when processing any specimens.

1. Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting must not be allowed.

2. Needles and syringes should be handled with extraordinary precautions, as described below.

> Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

3. Laboratory coats, gowns or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory. A plastic apron should be used to cover garments.

4. Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions and secretions, as well as surfaces, materials and objects contaminated by them.

5. All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.

6. Biological safety cabinets (Class I or II) and other primary containment devices (e.g., centrifuge safety cups) are required whenever procedures are conducted that have high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens. Whenever centrifugation of blood or body fluids from AIDS patients is necessary, the use of centrifuge safety caps is recommended.

7. Laboratory work surfaces should be decontaminated following any spill of potentially infectious material, the completion of work activities, and at

least daily. All potentially contaminated materials used in laboratory tests must be decontaminated, preferably by autoclaving, before disposal or reprocessing or sealed in leakproof containers for incineration.

Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used in hospitals and other facilities. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves.

8. All personnel should wash their hands following completion of laboratory activities, after removal of protective clothing and gloves, and before leaving the laboratory.

9. Eating, drinking and smoking is prohibited in the laboratory area.

References

CDC, "Acquired Immune Deficiency Syndrome (AIDS) Precautions for Clinical and Laboratory Staffs," MMWR, Volume 31, No. 43, November 5, 1982.

CDC, "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace," MMWR, Volume 34, No. 45, November 15, 1985.

LONG-TERM CARE FACILITIES

All persons with AIDS do not require acute hospital care. Some patients may be ambulatory, and seen only on an outpatient basis, while others may need skilled nursing care or hospice care.

The admission or contemplation of admission of a patient with AIDS to a long-term care facility may cause undue anxiety as a result of the misunderstanding of this syndrome. Transfer forms indicating the patient's diagnosis should be provided on a need-to-know basis.

Patients with AIDS can be admitted to long-term care facilities when so indicated by their clinical status and with the approval of their physicians. Restrictions in placement of patients in Montana's long-term care facilities may occur due to lack of available private rooms and limitations in staffing.

Considerations for long-term care facilities are the same as those specified in the beginning of this Section: Personnel Management and Hospitals. Additionally, an education program for all staff should be developed prior to the acceptance of a patient with AIDS into an long-term care facility. Appropriate education and training of staff members can diminish much of the fear and misunderstanding about AIDS, thus ensuring these patients the same high level of care offered to any other patient.

Reference

CDC, "Acquired Immune Deficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals," MMWR, Volume 32, September 2, 1983.

HOME HEALTH CARE

Measures similar to those used in hospitals are appropriate for use in the home.

1. Needles and other sharp items should be handled as described below and disposed of in accordance with local regulations for solid waste.

> Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

2. Blood and other body fluids can be flushed down the toilet. Other items for disposal that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy. It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal.

3. Spills or blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves.

4. An appropriate disinfectant solution should be used to wipe the area after cleaning. Chemical germicides registered with and approved by the U.S. Environmental Protection Agency (EPA) can be used in the home health care setting. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

Family members should be educated about transmission of blood-borne diseases, emphasizing principles of good hygiene, antisepsis and disinfection.

Reference

CDC, "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace," MMWR, Volume 34, No. 45, November 15, 1985.

DENTISTS AND DENTAL CARE PERSONNEL

OVERVIEW

Infection control in the dental setting should be emphasized at all times, but particularly when handling tissue, instruments, and materials, including dentures, which may be contaminated with oral secretion.

PATIENT SCREENING

A patient history form should be designed and reviewed periodically with patients to alert dental personnel to potential and diagnosed AIDS/HTLV-III or other infectious diseases.

It is recommended that known infectious patients be scheduled as the final cases of the day.

PERSONAL PROTECTION FOR STAFF AND PATIENTS

The use of physical barriers that either protect the body surfaces (such as gloves, eyeglasses, masks, rubber dams and protective clothing) or environmental surfaces (such as disposable covers for immovable dental operating apparatus), is recommended.

1. Clinic/office attire should be short-sleeved, clean and washable. Street clothes should not be worn.

2. Immunization for Hepatitis B is recommended.

If a health care worker has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III infection. If the source patient has AIDS/HTLV-III or other evidence of HTLV-III infection, declines testing, or has a positive test, the health care worker should be evaluated clinically and serologically for evidence of HTLV-III infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed health care workers should receive counseling about the risk of infection and following recommendations for preventing transmission of AIDS/HTLV-III. If the source patient is seronegative and has no other evidence of HTLV-III infection, no further follow-up of the health care worker is necessary.

It is important to evaluate the possible risk of AIDS/HTLV-III transmission after such accidental exposures. The Centers for Disease Control (CDC) Hospital Infections Program has initiated an active surveillance system

to evaluate and follow-up health care personnel who have documented parenteral or mucous membrane exposure to persons reactive to HTLV-III. Infection control personnel who have been notified of these types of accidental exposures in their institutions should contact the CDC Hospital Infections Program, (404) 329-3406. (See Appendix E for surveillance form.)

ASEPSIS

Basic aseptic techniques should be established in all dental offices, denturists' facilities and dental laboratories. Written guidelines for aseptic procedures should be posted. New personnel should be thoroughly oriented and periodic checks should be made to assure asepsis is effective.

1. Hand washing technique should be posted by all sinks (e.g., iodine soaps should be used especially before lunch and going home). Hand washing between patients and following glove removal should be stressed.

2. Use of disposable equipment items is recommended (e.g., disposable novocaine, pre-packed injection units).

3. Needles and syringes should be handled as follows:

> Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

STERILIZATION AND DISINFECTION

The distinction between sterilization and disinfection must be made. Sterilization is the destruction of all microbial forms. Disinfection properly refers only to the inhibition or the destruction of microbial pathogens. Disinfection commonly uses chemical agents and procedures which are unable to destroy microbial spores, mycobacterium tuberculosis, and hepatitis viruses.

Sterilization is the only component of control which consistently has the potential of reducing microbial count to zero. Any dental office not using heat and heat/pressure sterilization (example: autoclaves, chemical vapor, or dry heat sterilization and thereby using disinfectants is compromising infection control).

1. Efficacy of each system and the operators should be checked by use of monitors.

2. Representative samples of each should be stored in a quality assurance file. Studies show that approximately 1/3 of sterilizers investigated did not sterilize.

3. Process indicators are less dependable than control indicators.

4. Biological monitoring is the only dependable way to prove sterilization.

5. Quality assurance records should be kept and stored for at least three years (AIDS/HTLV-III can incubate for 1-6 years).

Since it is not possible to provide absolute asepsis for all surfaces and objects during dental procedures, strive to decontaminate those which are sources of cross-infection. Those include counter tops, light handles, switches, drawer handles, water faucets, x-ray cones, unit controls, couplings to saliva ejectors and hand pieces, and other hose endings, headrests and the arms of the dental chairs.

1. An appropriate disinfectant, such as iodophor 1:50 should be used for all impressions, dentures and other appliances.

2. Advise the dental laboratory of disinfected impressions or prosthesis and flag those that are not disinfected. Dental laboratories must be conscious of contaminated polishing equipment and materials (i.e., pumice, rag wheels).

3. Flag all material sent to dental laboratories that come from known infected patients (e.g., Hepatitis B carriers, AIDS/HTLV-III).

The most desirable disinfectants are sporicidal, tuberculocidal, and virucidal. When positive and negative factors are taken into account, iodophors emerge as the most appropriate group for routine use in surface disinfection.

Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse.

Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (including gloves) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Chemical germicides registered with and approved by the U.S. Environmental Protection Agency (EPA) should be used. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

Appendices F and G provide guides to chemical agents for disinfection/ sterilization, and describe the disinfectant characteristics of iodophors.

References

CDC, "Acquired Immune Deficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals," MMWR, Volume 32, No. 34, September 2, 1983, Vol. 32, No. 34.

CDC, "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace," MMWR, Vol. 34, No. 45, November 15, 1985

Mitchell, Edgar W., "Chemical Disinfecting/Sterilizing Agents," California Dental Association Journal, October, 1985, page 65.

Molinari, John A., "Surface Disinfection and Disinfectants," California Dental Association Journal, October, 1985, page 78.

PRE-HOSPITAL EMERGENCY HEALTH CARE

INTRODUCTION

Recommendations are made to minimize the chance of exposure to AIDS/HTLV-III, hepatitis B and other communicable diseases.

Law enforcement officers, emergency medical personnel, fire fighters, correctional officers and other public safety personnel have, in the course of their duties, close contact with many different persons in a variety of circumstances and environments. With the considerable media exposure of the AIDS/HTLV-III problem, these personnel are genuinely concerned with the risk of exposure to AIDS/HTLV-III and other communicable diseases. These groups frequently care for patients, or are otherwise in close contact with persons, without any knowledge of their medical history or current condition.

> PUBLIC SAFETY/EMERGENCY PERSONNEL HAVE A VERY LOW RISK OF ACQUIRING AIDS.

SPECIAL PRECAUTIONS IN PERFORMING ARTIFICIAL VENTILATIONS

There has been no documented transmission of AIDS virus during mouth to mouth resuscitation. However, because of the theoretical risk of salivary transmission of virus the following precautions are suggested for emergency care providers who regularly are involved in prehospital care:

1. The rescuer should use a Pocket Mask or other ventilatorv assistance device, when trained to do so.

2. Consideration should be given to the use of disposable airway equipment.

3. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

> PERSONS CHOOSING TO USE AN ARTIFICIAL VENTILATION DEVICE MUST BE TRAINED SO THAT THE CPR ITSELF IS NOT COMPROMISED BY A RESCUER CONCENTRATING MORE ON THE DEVICE THAN ON THE PATIENT. PERSONS MUST KNOW HOW TO USE THE DEVICE THEY ARE USING.

> IN SITUATIONS REQUIRING CARDIOPULMONARY RESUSCITATION, PERSONS MAY USE A POCKET MASK IF THEY ARE TRAINED AND IF IT IS READILY AVAILABLE. HOWEVER, CPR SHOULD NOT BE DELAYED DUE TO THE ABSENCE OF THE DEVICE. MOUTH TO MOUTH RESUSCITATION SHOULD BE BEGUN UNTIL THE DEVICE IS AVAILABLE!!

Cardiopulmonary resuscitation must be given to people in need of this lifesaving procedure. While there is some risk of being exposed to communicable disease during CPR, the risk is felt to be very small.

SPECIAL PRECAUTIONS WHEN EXPOSED TO BLOOD IN ASSISTING TRAUMA PATIENTS

It is always wise to be cautious and aware of infection control measures when assisting trauma patients.

1. Public safety personnel with wounds or abrasions on exposed body surfaces such as the hands or face should protect those areas from contact with blood or other body fluids.

2. Wearing of disposable gloves when in contact with blood or blood products is advised.

3. If contact with blood, urine, feces or other body secretions occurs, thorough washing with soap and water is important.

4. All non-disposable equipment known or suspected to be contaminated by blood or other body fluids should be thoroughly cleaned and appropriately disinfected after each use. Sterilization and disinfection procedures currently recommended for use in health care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III.

   Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse.

   Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used in hospitals and other facilities. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves.

   Chemical germicides registered with and approved by the U.S. Environmental Protection Agency (EPA) should be used. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

5. If the emergency care provider has a needlestick or cut or mucous membrane (e.g., splash to eye or mouth) exposure to blood or other body fluids, the provider should consult a physician and should inform their supervisor. If the provider's mucous membranes have been exposed to blood or other body fluids, immediately rinse with copious amount of water. Cut or lacerations of the emergency care provider which have been exposed to blood or other body fluids should be vigorously scrubbed with soap and water and be copiously irrigated.

CARE OF A PATIENT WITH AIDS

1. Wear disposable gloves.

2. Where practical to do so and where the amount of fluid is sufficient to warrant it, wear gowns or rubber aprons.

3. Decontaminate equipment exposed to body fluids with an appropriate disinfectant.

4. Put disposable contaminated articles in impervious bags for burning.

5. Place instruments or non-disposable equipment used for the patient in a clearly marked bag to indicate they need to be handled as though contaminated by a blood/body fluid transmitted disease.

6. Needles and other sharp items should be handled as described below and disposed of in accordance with local regulations for solid waste.

> Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

7. Contaminated linen should be double-bagged until washed in hot water. Bleach or other appropriate disinfectant should be added to the wash.

8. Use pocket mask or bag-valve-mask to resuscitate the patient. The risk of acquiring a communicable disease during CPR is very small:

> PERSONS CHOOSING TO USE AN ARTIFICIAL VENTILATION DEVICE MUST BE TRAINED SO THAT THE CPR ITSELF IS NOT COMPROMISED BY A RESCUER CONCENTRATING MORE ON THE DEVICE THAN ON THE PATIENT. PERSONS MUST KNOW HOW TO USE THE DEVICE THEY ARE USING.

> IN SITUATIONS REQUIRING CARDIOPULMONARY RESUSCITATION, PERSONS MAY USE A POCKET MASK IF THEY ARE TRAINED AND IF IT IS READILY AVAILABLE. HOWEVER, CPR SHOULD NOT BE DELAYED DUE TO THE ABSENCE OF THE DEVICE. MOUTH TO MOUTH RESUSCITATION SHOULD BE BEGUN UNTIL THE DEVICE IS AVAILABLE!!

9. Personnel with certain high risk illnesses (e.g. persons with known immunosuppressive diseases or receiving immunosuppressive medications) should not

be assigned to work with those AIDS/HTLV-III patients who have an easily transmissible infection.

10. Female emergency care providers who are pregnant are susceptible to a variety of infections. Therefore, it is recommended that the providers who are pregnant consult with their physician and follow his/her recommendations.

CPR TRAINING AND CONTAGIOUS DISEASE

There is no evidence to suggest that AIDS/HTLV-III may be transmitted among the staff or trainees at CPR training sessions. The Centers for Disease Control in cooperation with the American Heart Association and the American Red Cross have drafted guidelines about disease transmission and manikin decontamination in CPR training sessions.

The manikin decontamination procedures were originally developed because of concerns about Hepatitis B, although it has not been documented to occur in this way (it is more contagious than the AIDS virus).

All American Heart Association and American Red Cross CPR instructors are familiar with these decontamination procedures. In addition, both organizations have changed certain teaching procedures to reduce any possibility of disease transmission:

Two Person CPR

During two person CPR practice, the second person taking over ventilation on the manikin should simulate ventilation instead of blowing into the manikin. The manikin will then be properly cleaned after each sequence.

Obstructed Airway Sequence

Training of the "Obstructed Airway procedures" involves the student using his or her finger to sweep foreign matter out of the manikin's mouth. When practicing this procedure, the finger sweep should either be simulated or done on a manikin whose airway was decontaminated before the procedure and will be decontaminated after the procedure.

Persons involved with CPR training should follow the recommendations of the American Heart Association and the American Red Cross regarding course organization and manikin decontamination. These measures should be adequate for protection against all communicable diseases, including AIDS.

References

CDC, "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace: Precautions for Providers of Prehospital Emergency Health Care," MMWR, Volume 34, No. 45, November 15, 1985.

MORTICIANS' SERVICES/NECROPSIES

1. As part of immediate postmortem care, all deceased persons should be treated as infectious. (See "Blood/Body Fluid Precautions," Appendix C.)

2. The procedures to be followed before, during and after the postmortem examination are similar to those for patients who have died of hepatitis B (see Appendix C). All personnel involved in performing an autopsy should wear double gloves, masks, protective eyewear, gowns, waterproof aprons and waterproof shoe coverings. Instruments and surfaces contaminated during the postmortem examination should be handled as potentially infective items.

3. Morticians should evaluate specific procedures used in providing mortuary care and take appropriate precautions to prevent the parenteral or mucous membrane exposure of personnel to body fluids.

4. Methods that will avoid or minimize aerosol distribution of infectious agents should be used. As an example, bones should be cut with a hand saw rather than an electric saw.

5. The following should be decontaminated at the conclusion of an autopsy:

   -- Autopsy table.

   -- All contaminated instruments.

   -- Other contaminated items that cannot be disposed of or autoclaved, including the outside of tissue containers.

6. Tissue samples should be thoroughly fixed in 10% buffered formalin before trimming for histology.

Sterilization and disinfection procedures currently recommended for use in health care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III.

Chemical germicides registered with and approved by the U.S. Environmental Protection Agency (EPA) should be used. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used in hospitals and other facilities. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves.

Reference

CDC, "Acquired Immune Deficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals," MMWR, Volume 32, No. 34, September 2, 1983.

O P T O M E T R I S T S / O P H T H A L M O L O G I S T S

The following precautions are judged suitable to prevent spread of HTLV-III/LAV and other microbial pathogens that might be present in tears. They do not apply to the procedures used by individuals in caring for their own lenses, since the concern is possible virus transmission between individuals.

1. Health care professionals performing eye examinations or other procedures involving contact with tears should wash their hands immediately after a procedure and between patients. Handwashing alone should be sufficient, but when practical and convenient, disposable gloves may be worn. The use of gloves is advisable when there are cuts, scratches, or dermatologic lesions on the hands. Use of other protective measures such as masks, goggles, or gowns is <u>not</u> indicated.

2. Instruments that come into direct contact with external surfaces of the eye should be wiped clean and then disinfected by: (a) a 5 to 10 minute exposure to a fresh solution of 3% hydrogen peroxide; or (b) a fresh solution containing 5,000 parts per million (mg/L) free available chlorine -- a 1/10 dilution of common household bleach (sodium hypochlorite); or (c) 70% ethanol; or (3) 70% isopropanol. The device should be thoroughly rinsed in tap water and dried before reuse.

3. Contact lenses used in trial fittings should be disinfected between each fitting by one of the following regimens:

   a. Disinfection of trial hard lenses with a commercially available hydrogen peroxide contact lens disinfecting system currently approved for soft contact lenses. (Other hydrogen peroxide preparations may contain preservatives that could discolor the lenses.) Alternatively, most trial hard lenses can be treated with the standard heat disinfection regimen used for soft lenses (78-80 C [172-176 F) for 10 minutes). Practitioners should check with hard lens suppliers to ascertain which lenses can be safely heat-treated.

   b. Rigid gas permeable (RGP) trial fitting lenses can be disinfected using the above hydrogen peroxide disinfection system. RGP lenses may warp if they are heat disinfected.

   c. Soft trial fitting lenses can be disinfected using the same hydrogen peroxide system. Some soft lenses have also been approved for heat disinfection.

   Other than hydrogen peroxide, the chemical disinfectants used in standard contact lens solutions have not yet been tested for their activity against HTLV-III/LAV. Until other disinfectants are shown to be suitable for disinfecting HTLV-III/LAV, contact lenses used in the eyes of patients suspected or known to be infected with HTLV-III/LAV are most safely handled by hydrogen peroxide disinfection.

Reference

CDC, "Recommendations for Preventing Possible Transmission of HTLV-III/LAV from Tears," MMWR, Volume 34, No. 34, August 30, 1985.

SECTION III

GUIDELINES FOR PERSONAL SERVICE WORKERS AND FACILITIES/AGENCIES

PERSONAL SERVICE WORKERS

OVERVIEW

Personal service workers include individuals whose occupations involve close personal contact with clients, e.g., hairdressers, barbers, cosmetologists, manicurists, massage therapists, etc. Those workers whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions for health care workers (see Appendix C).

Although there is no evidence of transmission of HTLV-III from clients to personal service workers, from personal service workers to clients, and between clients of personal service workers, a risk of transmission would exist in situations where there is both:

1. Trauma to one of the individuals that would provide a portal of entry for viruses; and

2. Access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut.

A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients.

Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and discarded appropriately or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health care institutions.

Instruments not intended to penetrate the skin but which may become contaminated with blood, e.g., razors, should be used for only one client and be disposed of following the guidelines below, or should be thoroughly cleaned and disinfected after use following procedures outlined for health care institutions.

> Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

PERSONNEL PRACTICES

Employee Health

All personal service workers should be educated about the transmission of blood borne infections, including HTLV-III and Hepatitis B. Such education should emphasize principles of good hygiene, antisepsis, and disinfection.

Any personal service worker with exudative lesions or weeping dermatitis, regardless of HTLV-III infection status, should refrain from direct contact with clients until the condition resolves. Personal service workers known to be infected with HTLV-III need not be restricted from work unless they have evidence of other infections or illnesses for which any other personal service worker should also be restricted.

No person, while infected with a disease in a communicable form that can be transmitted by foods or who is a carrier of organisms that cause such a disease, or while afflicted with a boil, an infected wound, diarrheal illness or acute gastrointestinal illness or acute respiratory infection should work in a personal service establishment in any capacity in which there is a likelihood of such person contaminating food or food-contact surfaces with pathogenic organisms or transmitting disease to other persons.

Personal Cleanliness

Employees should thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean, and after smoking, drinking, or using the toilet. Employees also should keep their fingernails clean and trimmed.

Clothing

The outer clothing of all employees should be clean and washable.

Other Issues in the Workplace

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III infection. The diagnosis of HTLV-III infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

FOOD SERVICE ESTABLISHMENTS

Food Service Workers

In this group are individuals whose occupations involve the preparation or serving of food or beverages, including cooks, caterers, servers, waiters, bartenders, and airline attendants.

All food service workers should follow recommended standards of good personal hygiene and food sanitation, and should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded.

Employee Practices

Employees should consume food or beverages only in designated areas. An employee dining area should not be designated if consuming food there may result in contamination of other food, equipment, utensils, or other items needing protection.

Employees should not use tobacco in any form while engaged in food preparation or service, nor while in areas used for utensil washing or for food preparation. Employees should use tobacco only in designated areas. An employee tobacco-use area should not be available if the use of tobacco there may result in contamination of food, equipment, utensils, or other items needing protection.

Employees should handle soiled tableware in a way that minimizes contamination of their hands.

Employees with AIDS/HTLV-III

There is to date no evidence that the AIDS virus is spread by food prepared or served by an infected person; therefore, a person with AIDS or HTLV-III infection without any other communicable disease, should be allowed to continue employment in all aspects of food establishment operation and maintenance. However, to lessen the potential for spread of any communicable disease including AIDS, any person who cannot or will not conform to the personnel practices outlined at the beginning of this Section should not be allowed to continue to work in a food establishment.

Patrons with AIDS/HTLV-III

Because there is no evidence that AIDS is spread by utensils or dishes used by an infected person or through casual contact, persons with AIDS/HTLV-III should not be excluded from food establishments. However, employees (i.e., custodial staff, waitresses), of food establishments who may come into contact with body fluids of patrons should follow the procedures described in Appendix C, "Blood/Body Fluid Precautions," to lessen the potential for spread of any communicable disease including AIDS.

PUBLIC ACCOMMODATIONS

Employees with AIDS

Employees of public accommodations (hotels, motels, rooming houses, retirement homes) should not be directly involved in any type of resident care beyond housekeeping and laundry service. Because there is no evidence supporting casual contagion, a person with AIDS/HTLV-III should be allowed to continue employment in all aspects of public accommodation operation and maintenance.

Residents with AIDS

Employees (i.e., housekeeping, laundry, and custodial staff) of public accommodations who may come into contact with body fluids of residents should follow the procedures described in Appendix C, "Blood/Body Fluid Precautions," to lessen the potential for spread of any communicable disease including AIDS.

Persons with AIDS/HTLV-III may continue to reside in public accommodations only if they are not in need of personal care or nursing service and are able to handle their own body secretions. Precautionary measures indicated for public accommodations in which persons with AIDS/HTLV-III reside are the same as those specified in SECTION II, Personnel Management. In addition, an education program should be developed prior to the acceptance of a person with AIDS/HTLV-III within such an establishment. In accordance with MCA 50-51-107, a resident of a public accommodation who becomes in need of personal care or nursing services provided by the establishment should be transferred to an establishment licensed to provide such services.

S W I M M I N G P O O L S

Employees with AIDS/HTLV-III

There is no evidence supporting casual contagion, thus a person with AIDS should be allowed to continue employment in all aspects of pool operation and maintenance.

Swimmers with AIDS/HTLV-III

As there is no evidence that AIDS/HTLV-III is spread through swimming pools, persons with AIDS/HTLV-III should not be excluded from pools. In order to lessen the potential for spread of any communicable disease including AIDS, it is important that disinfectant levels be kept above the required minimum, that spitting or blowing the nose in the pool be prohibited, and that persons with open sores or diarrhea be excluded from the pool.

Pool employees (i.e., custodial staff, first aid staff) who may come into contact with body fluids of patrons should follow the procedures described in Appendix C.

Reference

CDC, "Recommendations for Preventing Transmission of Infection With HTLV-III/LAV in the Workplace," MMWR, Volume 34, No. 45, November 15, 1985.

SECTION IV

GUIDELINES FOR INSTITUTIONS

CUSTODIAL INSTITUTIONS

Admission of a patient with AIDS/HTLV-III to an institution may be disruptive to normal routine and impair the ability of the institution to function effectively. Anxiety and misunderstanding about the syndrome can result in problems with personnel management, maintaining patient census, and public relations. Anticipating these problems and planning for them can avoid their occurrence.

The institution should recognize that the admission of an AIDS patient may cause substantial anxiety among some staff members and patients who are concerned about their personal safety. Moreover, a person with AIDS may also be anxious and is having to cope with a serious disease. AIDS patients have sometimes been shunned or abandoned by family and friends, and they may be similarly neglected or abused by personnel unless special supportive steps are taken by staff members. These nonmedical needs of both patients and staff may become so pressing that care of all patients may be compromised.

Nationally, institutions which have developed aggressive, ongoing education and intervention programs for their staff, including the medical staff, have been successful in minimizing anxiety and disruption. Intensive efforts at education and crisis intervention by skilled and respected personnel are perhaps the most useful activities to ensure that an institution continues to function adequately when an AIDS patient is present.

Teams of staff members (AIDS coordinating teams) who are readily available to answer medical and other questions about AIDS/HTLV-III, advise about appropriate practices, and provide support to personnel and patients have been found to be highly useful. These teams usually include persons such as an infection control nurse, a psychiatric social worker, a psychiatrist or psychologist, a nursing administrator and a patient advocate.

Widespread and open discussion about AIDS and the issues raised in treating patients with AIDS/HTLV-III appears to be beneficial, especially when this discussion occurs before a patient is actually admitted.

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III infection. The diagnosis of HTLV-III infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

SECTION V

GUIDELINES FOR SCHOOLS AND DAY CARE CENTERS

ALTERING CHILD CARE PRACTICES WHEN A CHILD HAS AIDS/HTLV-III

SCHOOLS AND DAY CARE CENTERS

BACKGROUND

As of December 16, 1985 226 children in the U.S. under the age of 13 have been diagnosed with AIDS/HTLV-III. Most of these children became ill very early in life (at less than one year of age), having contracted the infection either congenitally or from blood transfusions. No family members of these children have become ill from contact with the children. However, until we know more about AIDS/HTLV- III, day care workers, school teachers, and others should exercise the same precautions they would take with an adult with AIDS/HTLV-III.

The recommendations which follow apply to all children known to be infected with human T-lymphotropic virus type III (HTLV-III). This includes children with AIDS/HTLV-III; children who are diagnosed by their physicians as having an illness due to infection with HTLV-III but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III.

The CDC provisional case definition of AIDS/HTLV-III in children is reproduced in Appendix B.

SCHOOL ATTENDANCE GUIDELINES

The question of children with AIDS/HTLV-III attending day care or school is not strictly a medical matter. The following recommendations and infection control procedures are intended to provide the initial framework for development of subsequent guidelines by all parties concerned. Each child infected with HTLV-III should be considered individually.

1. A child with AIDS/HTLV-III should be allowed to attend day care and school in a regular classroom setting with the approval of the student's physician.

2. Day care centers and schools should attempt to use the least restrictive means to accommodate the child's needs and the infection control recommendations.

3. Infected children should be allowed to attend day care or school as long as they are toilet trained, have no uncoverable open sores or skin eruptions, and do not bite. Students (K-12) who are excluded should receive adequate alternative education through homebound or other programs.

4. Children with AIDS/HTLV-III should be temporarily removed from day care or school if measles or chickenpox is occurring in the school population (e.g., cases occurring in classroom or close non-classroom contacts). This also applies to other children with immune system abnormalities.

5. Children with AIDS/HTLV-III should be temporarily removed from day care or school when they are acutely ill, as should any child.

6. The day care center or school should respect the right to privacy of the individual; therefore, knowledge that a child has AIDS/HTLV-III should be confined to those selected persons with a direct need to know (e.g., principal, school nurse, child's teacher or day care director). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements.

7. The school nurse or other knowledgeable person should be appointed as the child's advocate to assist in problems that arise, provide educational materials answer questions and act as liaison with the child's physician.

GENERAL PRECAUTIONS

1. Good personal hygiene is probably the best protection against infection with HTLV-III virus, with careful handwashing being the single most important personal hygiene practice. Handwashing, combined with a common-sense avoidance, removal or reduction of possible sources of infection is important in all communicable disease control, including HTLV-III/AIDS. Handwashing applies even if gloves are worn.

2. Disposable gloves should be used any time there will be contact with blood, urine, feces, semen or saliva. Hands should be thoroughly washed after gloves are discarded.

3. Through cleaning of surfaces contaminated with blood and other body fluids followed by use of disinfectants, must be maintained.

   Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves.

   Laundry and dishwashing cycles commonly used in public facilities are adequate to decontaminate linens, dishes, glassware and utensils.

   Chemical germicides registered with and approved by the U.S. Environmental Protection Agency (EPA) should be used. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

PERSONAL CONTACT

1. Direct mouth-to-mouth or genital contact should be avoided with persons with AIDS/HTLV-III. Activities such as mouth-to-mouth kissing should be discouraged.

2. Mouth-to-mouth sharing of food and other objects (e.g., pencils, gum, toys) between children should be discouraged.

3. Personal toiletry items (e.g., towels, toothbrushes, razors) and tools (e.g., scissors, nail files, woodworking tools) which may potentially cause cutting injuries should not be shared by persons with AIDS/HTLV-III and others. Toothbrushes should not be available in day care or pre-school situations.

CONTACT WITH BLOOD OR OTHER BODY FLUIDS

1. Care should be taken to minimize breaks in the skin (for example, hand lotion can be used to minimize chapping). If the person with AIDS/HTLV-III has breaks in the skin, the care provider should use gloves when touching those areas.

2. Bleeding or oozing cuts or abrasions (in either the care giver or a person with AIDS/HTLV-III) should be covered (gauze, bandaids, etc.) whenever possible. The care provider's fingernails should be kept trimmed and clean.

3. Care providers should avoid direct skin contact with blood while caring for nose bleeds, bleeding or oozing wounds, or menstrual accidents in a person with AIDS/HTLV-III. Disposable gloves should be used in these situations.

4. Gloves, sanitary napkins, gauze pads or any other materials which are soiled should be carefully and promptly discarded in leakproof, sealed plastic bags or containers. Ultimate disposal is by incineration or placement in a properly supervised and maintained sanitary landfill.

5. Environmental surfaces soiled with blood should be thoroughly cleaned as recommended previously.

SOILED ITEMS

1. Items soiled by blood, saliva or other body fluids from a person with AIDS/HTLV-III should not be used by others; these items should be discarded or thoroughly cleaned with soap and water and disinfected with an appropriate disinfectant before reuse.

2. Dishes -- Washing of dishes with plenty of hot, soapy water, followed by thorough rinsing, is recommended. An electric dishwasher can also be utilized for dishwashing. Separate dishwashing is not needed for dishes or utensils used by someone with AIDS/HTLV-III.

3. Laundry -- Blood-contaminated items should be handled with appropriate precautions (gloves, apron and any other cover-up needed to prevent direct exposure to blood). Washing with soap, hot water and bleach, followed by thorough rinsing is suggested. A washing machine and dryer can be utilized. Separate laundering is not necessary for items used by a child with AIDS/HTLV-III. It is of importance to thoroughly scrape and clean adherent materials from objects and surfaces before laundering.

EMPLOYEES WITH AIDS/HTLV-III

The determination of whether an infected school employee should be permitted to remain employed in a capacity that involves contact with students or other

school employees should be made on a case-by-case basis. In making this determination, consideration should be given: (1) the physical condition of the school employee; (2) the expected type of interaction with others in the school setting; and (3) the impact on both the infected school employee and others in that setting.

The sexual orientation of a school employee is not cause to believe that he or she is an infected individual. No school employee or potential school employee should be required to provide information as to his/her sexual orientation.

School districts who have employees with reactive HTLV-III tests are urged to solicit advice from their legal counsel and the state epidemiologist (444-4740).

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III infection. The diagnosis of HTLV-III infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

References

CDC, "Education and Foster Care of Children Infected with HTLV-III/LAV," MMWR, Volume 34, No. 34, August 30, 1985.

CDC, "Recommendations for preventing Transmission of Infection with HTLV-III/LAV in the Workplace," MMWR, Volume 34, No. 45, November 15, 1985.

"Guidelines for Children with AIDS/ARC Attending School," Indiana State Board of Health, July, 1985.

"Minnesota Department of Health Guidelines for the Placement in Schools of Children and Adolescents Infected with HTLV-III," September, 1985.

NEA, "Recommended Guidelines for Dealing With AIDS in the Schools," NEA Now, National Education Association, Washington, D.C., October 14, 1985.

ALTERING CHILD CARE PRACTICES WHEN A CHILD HAS AIDS/HTLV-III

Some child care practices need to be altered when the child has AIDS/HTLV-III. The following recommendations, as well as the General Precautions on the previous pages provide guidance for parents and foster parents.

Bottle Feeding: Sterilization of bottles is recommended for the immunosuppressed infant. Soak bottles in water after use to prevent milk from hardening and being difficult to remove. Gloves should be worn when feeding the child if the caregiver has a cut or dermatitis. Hold the baby during feedings.

Oral Hygiene: Oral hygiene in infancy is a good practice, although children's mouths are not usually attended until they have teeth.

Feeding Utensils: Do not feed the child with your fingers or hands; use utensils. Wash all utensils with hot sudsy water followed by a thorough rinsing, or wash in a dishwasher.

Diaper Care: Use gloves when changing diapers. Hands should be washed before and after. To avoid any skin breakdown, wash child carefully, dry and powder. Usual ointments are fine. Do not share the ointments with other children. Disposable diapers should be placed in plastic bags and tied securely prior to disposing.

Hugging and Holding: Do not avoid comforting the child. Hugging and kissing on the cheek do not spread the virus.

Prevention of Rashes: As the immune suppressed child's body provides little skin defense against common germs, caution must be exercised to maintain the child's skin, to keep it clean and intact. Regular baths, proper drying, use of lotions to prevent dryness or irritations are all required. Keep tubs free of detergents which might cause dermatitis or irritations. Protect children from both sun and wind burns. Use vaseline on skin in cold weather and shield the child from the sun. If the child has a cold, wash face and hands more frequently.

Care of Nails and Feet: Cut nails straight across and keep short to avoid infection or ingrowing and to minimize scratching. Dry feet after bath to prevent fungal infections which like to grow in dampness. Observe feet for irritations from shoes and possible skin allergies to shoes.

Pacifiers: Sterilize at least once a day by boiling in water for at least five minutes.

Drooling: Use a disposable cloth to wipe off drools. Keep skin clean from saliva. Wash hands with soap and water after handling any oral secretions.

Laundry: It is not necessary to keep the child's clothing separate from other household members' clothing. Use as many disposable items as practical. Diapers used to burp and sheets which may be soiled (though not visibly) by saliva or excreta should be washed in hot water using mild detergents and bleach and rinsed thoroughly to avoid any bleach burns.

Toys: Do not allow the child's toys to be shared or borrowed. TOYS SHOULD BE WASHED DAILY.

Fresh Air: As child's contact with other children may be limited, outdoor play will prove an opportunity to compensate for isolation and will provide opportunities to stimulate the child, i.e., walks, window shopping, visits to museums, etc.

Using Park: Children can go on swings and play in parks but should not be taken out if they are sick.

COMMON ILLNESSES AND CHILDREN WITH AIDS/HTLV-III

Though parents are generally encouraged to handle minor illnesses at home, for foster care children it is recommended that the foster care staff be contacted at the very beginning of even minor problems. Since the AIDS/HTLV-III child does not handle infections as well as the healthy child does, it is important for you to recognize the signs and symptoms of common illnesses. These include: red watery eyes, sticky eyelids, red scaly skin, running nose, fever, sore throat, cough, increased tiredness, muscle aches, crankiness, change in appetite, vomiting, diarrhea, rashes, sores around the mouth. As the child with AIDS/HTLV-III may have already had bacterial, viral or fungal infections, any recurrence of these illnesses must immediately be reported.

TREATING COMMON ACCIDENTS AND ILLNESSES

To help monitor the child's health, a rectal thermometer is necessary. It should be stored in a glass container with a disinfectant (such as 0.2% iodine in 70-80% alcohol) which is changed every three days. Do not use this thermometer for anyone else. If the child becomes ill with diarrhea or vomiting, mask and gloves should be used by the caregiver at the time of washing and diaper changes if sprays are expected to be produced. Be certain toys or equipment soiled with feces or vomitus are thoroughly cleaned.

Any trauma to the skin should be considered of greater importance than in a healthy child.

Gloves should be worn for treating any cuts, bites, nosebleeds, bee stings or burns. Any dressings or bandages used to clean and protect the child should be discarded in a sealed plastic bag. The sealed bag should be incinerated or sent to a properly supervised and maintained sanitary landfill in accordance with local solid waste regulations.

PREVENTION OF DISEASE

The usual immunization schedule for children will be altered. Immunizations containing live viruses (such as oral polio and measles) should not be given; substitutions will be required. Some additional vaccinations against flu or pneumonia may be advised. Medical examinations and check-ups may be scheduled far more frequently than usual. The physical growth of the child may need to be monitored more closely than usual.

Sick Family Members: Try to prevent children from visiting with others who are sick. It is recognized that total isolation is not required, but be prudent. If you become ill, an alternate care giver may be necessary.

Group Play: Initially, with pre-schoolers, it will be advisable to avoid group play experiences. Assistance should be obtained in planning a stimulating home, developing educational programs, explaining medical procedures to the child and discussing fears.

Pets: Pets provide an important source of stimulation and contact for many children, but may provide cause for concern for the child with AIDS/HTLV-III because of injury and disease they may transmit.

Use of Over-the-Counter Medications: Do not administer any drug without the approval of the child's physician.

Reference

CDC, "Education and Foster Care of Children Infected with HTLV-III/LAV," MMWR, Volume 34, No. 34, August 30, 1985.

SECTION VI

REPORTING REQUIREMENTS, CONFIDENTIALITY AND PUBLIC RELATIONS

REPORTING REQUIREMENTS, CONFIDENTIALITY, AND PUBLIC RELATIONS

REPORTING REQUIREMENTS

HTLV-III testing must be reported to DHES by the laboratories or physicians who do it. If the results of a test are positive, a report must be submitted to DHES by 5 p.m. Friday of the week in which the test is performed and a second blood specimen must be obtained, if possible, and submitted to DHES' microbiology laboratory for confirmation of the results. A reporting card is available from DHES for all reports of positive HTLV-III antibody tests (see Appendix H).

A form for reporting the number of such tests with negative results which are done each month is available from DHES and must be submitted to DHES by the 15th day of the month following the one in which the tests are performed (a sample form is in Appendix H).

Cases of AIDS must be reported to both DHES and the local health officer of the county from which the report emanates by 5 p.m. Friday of the week in which the diagnosis is made; such case reports must contain the information required by DHES' confidential case card, available from DHES.

A copy of the current rules specifying reporting requirements is in Appendix J.

CONFIDENTIALITY

Disclosure of any case reports and related patient information is prohibited, except under the circumstances allowed by Title 50, Chapter 16, Montana Code Annotated (see Appendix I). DHES' rules also prohibit release of the names of those who report AIDS cases or HTLV-III test results.

As for minors who want to have themselves tested for the AIDS virus antibody or to see a doctor because they suspect they might have AIDS, Montana law allows them to receive such services from a hospital, public clinic, or physician without the consent of parent, custodial, guardian, or spouse because a communicable disease is involved. However, the law does give the health professional the choice, though not the obligation, to inform the parent, guardian, custodian, or spouse if, in the professional's judgement, severe complications are likely; major surgery or prolonged hospitalization is needed; the health and safety of the minor, the minor's younger siblings, or the public would be otherwise jeopardized; the minor's physical and mental health and family harmony would benefit; or, in the case of a hospital, the hospital wants a third party to be committed to pay for the services. (See Sections 41-1-402 and 4-1-1403, MCA.)

Health care facilities and institutions should be careful to balance the need to ensure appropriate precautions to prevent spread of disease with the need to ensure appropriate confidentiality of their patients. Patients with AIDS, like other patients with diseases spread by blood, will need to have laboratory tests performed, and they may need other specialized procedures such as surgery or other invasive procedures. In addition, they may need to be transported to

other hospital departments or clinics for proper management. The facility should develop a transfer procedure that ensures that staff who care for these patients in other departments/clinics know what precautions need to be taken. Because of the publicity that AIDS has received, however, special care needs to be taken to preserve the dignity and confidentiality of persons with AIDS. Unless such procedures are outlined, there are dangers 1) that patients will not be appropriately identified, 2) that proper precautions will not be taken, or alternatively, 3) that confidentiality will not be preserved. The general designation "Blood/Body Fluid Precautions" should be sufficient, if utilized uniformly. The precautions, but not the diagnosis, should be clearly identified.

PUBLIC RELATIONS

Public relations issues present both problems and opportunities. Some health care facilities and institutions have found that the treatment of patients with AIDS has had adverse public relations consequences. Occasionally, members of the press will place disruptive and time-consuming demands upon staff. On the other hand, patients or members of the staff may make inappropriate requests, such as asking that AIDS patients not be treated in the facility or institution. The institution must not allow these disruptions to interfere with patient care. Education will often allay inappropriate concerns and in many communities, contact with news media will present unique opportunities for public education about AIDS.

In dealing with the press, careful and honest sharing of information is recommended to diminish adverse publicity and promote public education. The facility should establish several principles for dealing with the press: first, patient confidentiality and dignity must be preserved; second, a knowledgeable and authoritative person should be the designated representative to the press, with other staff members coordinating all press communications through that representative.

SECTION VII

RESOURCES FOR FURTHER INFORMATION

MONTANA AIDS TASK FORCE

Montana DHES has a Task Force for considering issues relating to AIDS/HTLV-III and making recommendations. The Task Force has five subcommittees; 1) Education, 2) Funding, 3) Policies, 4) Medical Advisory and 5) Prevention. Task Force members are available to present educational and informational forums concerning AIDS. Persons or groups desiring such presentations should contact the Nursing Bureau at (406) 444-4740, or one of the Task Force Speakers' Bureau members.

TASK FORCE MEMBERS

John J. Drynan, M.D., Director

*William J. Opitz, Deputy Director

*Robert L. Solomon, M.P.H., Administrator, Management Services Division and Task Force Coordinator

* Douglas O. Abbott, Ph.D., Chief, Microbiology Laboratory Bureau
* James P. Brinker, B.S., Microbiologist, Virus Section Supervisor
* Drew Dawson, E.M.T., Chief, Emergency Medical Services Bureau
* Donald E. Espelin, M.D., Director, Montana Perinatal Program
George M. Fenner, Administrator, Health Services and Medical Facilities Division
* Maxine Ferguson, R.N., M.N., Chief, Nursing Bureau
* Judith G. Gedrose, R.N., M.N., State Epidemiologist
* William G. Haggberg, D.D.S., Chief, Dental/Health Education Bureau
Raymond Hoffman, Administrator, Financial Management Division
* Barbara A. Meek, B.S., Public Health Advisor
* Robert W. Moon, M.P.H., Health Education Specialist
* M. Richard Nelson, B.S., Program Supervisor, Sexually Transmitted Diseases
Ellie Parker, J.D., Legal Counsel
James M. Peterson, R.S., Chief, Food and Consumer Safety Bureau
Sidney C. Pratt, M.D., Chief, Clinical Programs Bureau
Joe A. Renders, Information Officer
§ Louise Salo, R.D., M.S., Nutrition Coordinator
§ Yvonne Sylva, M.P.A., Administrator, Management Services Division
John C. Wilson, Chief, Records and Statistics Bureau

*Speakers' Bureau members (also includes Bruce Desonia, Stephen Linder and Richard Paulsen)

§Position at time of participation on Task Force.

COMMUNICABLE DISEASE ADVISORY COMMITTEE

Ronald H. Smith, M.D., Billings
M. J. Winship, M.D., Missoula
John Pullman, M.D., Butte
James Silva, D.D.S., Butte

INFORMATION RESOURCES

Montana State Department of Health
and Environmental Sciences
(406) 444-4740
Sexually Transmitted Diseases
Program
Cogswell Building
Helena, MT 59620

Maintains the most current information available about the disease and its control. Educational offerings are available. Will assist local providers upon request.

NGTF AIDS Hotline
1-800-221-7044

Toll-free national hot line run by the National Gay Task Force to provide information and referrals.

United Blood Service
(406) 248-9168
3000 7th Avenue North
Billings, MT 59101

Provides information on donor eligibility and safety of the blood supply.

American Red Cross
Blood Services -- Montana Region
(406) 727-2212
1300 28th Street South
Great Falls, MT 59401

Provides information on donor eligibility and safety of the blood supply.

AIDS Information
U.S. Public Health Service
(202) 245-6867
Room 721-H, HHH Building
200 Independent Avenue, S.W.
Washington, D.C. 20201

Provides AIDS information materials and periodic updates on AIDS for lay and professional public.

HTLV-III ANTIBODY TEST SITES

		Phone
BILLINGS	Deering Community Health Center	(406) 256-6821
BOZEMAN	Gallatin County Health Department	(406) 587-4297
BUTTE	Butte Silver Bow City-County Health Department	(406) 723-3271
GREAT FALLS	Cascade City-County Health Department	(406) 761-1190
HELENA	Family Practice Center STD Clinic	(406) 442-0120
KALISPELL	Flathead City-County Health Department	(406) 755-5300, Ext. 343
MISSOULA	Missoula City-County Health Department	(406) 721-5700, Ext. 358

Provides counseling, and education to persons requesting blood testing; provides information and education to health professionals and public.

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Table of Contents

	Page
Pneumocystis pneumonia-Los Angeles. MMWR 1981 June 5,30:250-2.	1
Kaposi's sarcoma and *Pneumocystis* pneumonia among homosexual men—New York City and California. MMWR 1981 July 3,30:305-8.	2
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Update: acquired immunodeficiency syndrome (AIDS)—United States. MMWR 1983 Aug 5,32:389-91.	41
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Update: Acquired Immunodeficiency Syndrome — Europe 98
Update: Public Health Service Workshop on Human T-Lymphotropic Virus Type III Antibody Testing — United States 102
Isolation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus from Serum Proteins Given to Cancer Patients — Bahamas 103
Results of a Gallup Poll on Acquired Immunodeficiency Syndrome — New York City, United States, 1985 104
Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus 106
Recommendations for Preventing Possible Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus from Tears 109
Update: Revised Public Health Service Definition of Persons Who Should Refrain from Donating Blood and Plasma — United States 110
Oral Viral Lesion (Hairy Leukoplakia) Associated with Acquired Immunodeficiency Syndrome 111
Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus 112
Update: Acquired Immunodeficiency Syndrome in the San Francisco Cohort Study, 1978-1985 114
Update. Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection in Health-Care Personnel — United States 116
Update: Acquired Immunodeficiency Syndrome — Europe 118
Index 125

SECTION VIII

APPENDICES

APPENDIX A

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

June 28, 1985 / Vol. 34 / No. 25

373 Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States

Current Trends

Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States

Patients with illnesses that, in retrospect, were manifestations of acquired immunodeficiency syndrome (AIDS) were first described in the summer of 1981 (*1,2*). A case definition of AIDS for national reporting was first published in the *MMWR* in September 1982 (*3,4*). Since then, the definition has undergone minor revisions in the list of diseases used as indicators of underlying cellular immunodeficiency (*5-8*).

Since the 1982 definition was published, human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) has been recognized as the cause of AIDS. The clinical manifestations of HTLV-III/LAV infection may be directly attributable to infection with this virus or the result of secondary conditions occurring as a consequence of immune dysfunction caused by the underlying infection with HTLV-III/LAV. The range of manifestations may include none, nonspecific signs and symptoms of illness, autoimmune and neurologic disorders, a variety of opportunistic infections, and several types of malignancy. AIDS was defined for national reporting before its etiology was known and has encompassed only certain secondary conditions that reliably reflected the presence of a severe immune dysfunction. Current laboratory tests to detect HTLV-III/LAV antibody make it possible to include additional serious conditions in the syndrome, as well as to further improve the specificity of the definition used for reporting cases.

The current case definition of AIDS has provided useful data on disease trends, because it is precise, consistently interpreted, and highly specific. Other manifestations of HTLV-III/LAV infections than those currently proposed to be reported are less specific and less likely to be consistently reported nationally. Milder disease associated with HTLV-III/LAV infections and asymptomatic infections may be reportable in some states and cities but will not be nationally reportable. Because persons with less specific or milder manifestations of HTLV-III/LAV infection may be important in transmitting the virus, estimates of the number of such persons are of value. These estimates can be obtained through epidemiologic studies or special surveys in specific populations.

Issues related to the case definition of AIDS were discussed by the Conference of State and Territorial Epidemiologists (CSTE) at its annual meeting in Madison, Wisconsin, June 2-5, 1985. The CSTE approved the following resolutions:

1. that the case definition of AIDS used for national reporting continue to include only the more severe manifestations of HTLV-III/LAV infection; and

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

AIDS – Continued

2. that CDC develop more inclusive definitions and classifications of HTLV-III/LAV infection for diagnosis, treatment, and prevention, as well as for epidemiologic studies and special surveys; and
3. that the following refinements be adopted in the case definition of AIDS used for national reporting:
   a. In the absence of the opportunistic diseases required by the current case definition, any of the following diseases will be considered indicative of AIDS if the patient has a positive serologic or virologic test for HTLV-III/LAV:
      (1) disseminated histoplasmosis (not confined to lungs or lymph nodes), diagnosed by culture, histology, or antigen detection;
      (2) isosporiasis, causing chronic diarrhea (over 1 month), diagnosed by histology or stool microscopy;
      (3) bronchial or pulmonary candidiasis, diagnosed by microscopy or by presence of characteristic white plaques grossly on the bronchial mucosa (not by culture alone);
      (4) non-Hodgkin's lymphoma of high-grade pathologic type (diffuse, undifferentiated) and of B-cell or unknown immunologic phenotype, diagnosed by biopsy;
      (5) histologically confirmed Kaposi's sarcoma in patients who are 60 years old or older when diagnosed.
   b. In the absence of the opportunistic diseases required by the current case definition, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative.
   c. Patients who have a lymphoreticular malignancy diagnosed more than 3 months after the diagnosis of an opportunistic disease used as a marker for AIDS will no longer be excluded as AIDS cases.
   d. To increase the specificity of the case definition, patients will be excluded as AIDS cases if they have a negative result on testing for serum antibody to HTLV-III/LAV, have no other type of HTLV-III/LAV test with a positive result, and do not have a low number of T-helper lymphocytes or a low ratio of T-helper to T-suppressor lymphocytes. In the absence of test results, patients satisfying all other criteria in the definition will continue to be included.

CDC will immediately adopt the above amendments to the case definition of AIDS for national reporting. This revision in the case definition will result in the reclassification of less than 1% of cases previously reported to CDC. The number of additional new cases reportable as a result of the revision is expected to be small. Cases included under the revised definition will be distinguishable from cases included under the old definition so as to provide a consistent basis for interpretation of trends. CDC will also develop draft classifications for disease manifestations of HTLV-III/LAV infections other than AIDS, distribute these widely for comment, and publish the results.

Reported by Conference of State and Territorial Epidemiologists; AIDS Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

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APPENDIX B

Provisional Case Definition of AIDS in Children
Centers for Disease Control
August 30, 1985

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric AIDS as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and

2. No known cause of underlying cellular immune deficiency or any other reduced resistance reported to be associated with the disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults, with the exclusion of congenital infections; e.g., toxoplasmosis or herpes simplex virus infection in the first six months after birth.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases -- severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinenia, or hypogammaglobulinemia with raised IgM.

2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy or starvation.

In the absence of the opportunistic disease required by the case definition, a histologically confirmed diagnosis of chronic lymphoid intersitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative.

Reference

CDC, "Education and Foster Care of Children Infected with HTLV-III/LAV," Volume 34, No. 34, August 30, 1985.

APPENDIX C

Blood/Body Fluid Precautions

Blood/Body Fluid Precautions are designed to prevent infections that are transmitted by direct or indirect contact with infective blood or body fluids. Infectious diseases included in this category are those that result in the production of infective blood or body fluids, unless the disease is included in another isolation category that requires more rigorous precautions, for example, strict isolation. (If you have questions about a specific disease, see the alphabetical listing of infectious diseases in Table A, Category-Specific Isolation Precautions.) For some diseases included in this category, such as malaria, only blood is infective; for other diseases, such as hepatitis B (including antigen carriers) blood and body fluids (saliva, semen, etc.) are infective.

SPECIFICATIONS FOR BLOOD/BODY FLUID PRECAUTIONS

1. A private room is indicated if patient hygiene is poor. A patient with poor hygiene does not wash hands after touching infective material, contaminates the environment with infective material, or shares contaminated articles with other patients. In general, patients infected with the same organism may share a room.

2. Masks are not indicated.

3. Gowns are indicated if soiling of clothing with blood or body fluids is likely.

4. Gloves are indicated when handling blood or body fluids or items contaminated by blood or body fluids.

5. Hands must be washed immediately if they are contaminated with blood or body fluids and before taking care of another patient. Thorough handwashing is recommended even when gloves are worn, and is recommended between gloving for successive patients.

6. Articles contaminated with blood or body fluids should be discarded by proper bagging or should be bagged and labeled before being sent to the laundry or for other processing.

7. Care should be taken to avoid needle-stick injuries.

Disposable syringes and needles, scalpel blades, razors, and other sharp items should be placed into a rigid wall, puncture resistant container located as close as practical to the area in which they are used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken or clipped, removed from syringes or otherwise manipulated by hand.

8. Blood spills should be cleaned up promptly with an appropriate disinfectant, such as a freshly prepared solution of 5.25% sodium hypochlorite (household bleach) diluted 1:10 with water or other EPA-approved germicide.

DISEASES REQUIRING BLOOD/BODY FLUID PRECAUTIONS

Acquired immunodeficiency syndrome (AIDS)
Arthropodborne viral fevers (e.g., dengue, yellow fever, and Colorado tick fever)
Babesiosis
Creutzfeldt-Jakob disease
Hepatitis B (including HBsAg antigen carrier)
Hepatitis, non-A non-B
Leptospirosis
Malaria
Rat-bite fever
Relapsing fever
Syphilis, primary and secondary with skin and mucous membrane lesions.

Adapted from: "Guideline for Isolation Precautions in Hospitals," Centers for Disease Control, U.S. Department of Health and Human Services, 1983.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
PERSONNEL EXPOSURE REPORT FORM

INITAL
CASE REPORT FORM

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

APPENDIX D

EMPLOYEE INFORMATION

DATE OF REPORT ☐☐ Month ☐☐ Day ☐☐ Year

CASE REPORT NUMBER ☐☐☐

CENTER NUMBER ☐☐

DATE OF BIRTH ☐☐ Month ☐☐ Day ☐☐ Year

AGE ☐☐ Years

SEX ☐ Male ☐ Female

MARITAL STATUS ☐ Never Married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RESIDENCE _____ City _____ County _____ State ___ Zip Code

RACE/ETHNIC ORIGIN: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Is employee of Hispanic (Latin American) origin? ☐ Yes ☐ No

Did employee immigrate to U.S.? ☐ Yes ☐ No If yes, date of arrival in U.S. Month ____ Year ____

If employee or either parent was born outside U.S., check country/territory of birth/origin: ☐ Canada ☐ Puerto Rico

☐ Dominican Republic ☐ Haiti ☐ Mexico ☐ Cuba ☐ Cambodia/VietNam/Laos ☐ Other (specify)_____

PAST MEDICAL HISTORY: (check all that apply)

☐ Diabetes mellitus, insulin-dependent
☐ Chronic anemia
☐ Chronic renal failure
☐ Malignancy
☐ Hepatitis, chronic
☐ Tuberculosis
☐ Bleeding disorder/clotting factor deficiency
☐ Other infections (specify) _____

HOSPITALIZATIONS WITHIN THE PAST 5 YEARS: ☐ Yes ☐ No

		Month	Day	Year
Diagnosis: _____	Date	____	____	____
_____	Date	____	____	____
_____	Date	____	____	____

TRANSFUSIONS OF BLOOD OR PACKED RED BLOOD CELLS WITHIN THE PAST 5 YEARS: ☐ Yes ☐ No ☐ Unknown

Number of units _____ Date _____

TRANSFUSIONS OF OTHER BLOOD PRODUCTS (e.g., platelets, plasma, cryoprecipitate, Factor IX concentrate) WITHIN THE PAST 5 YEARS: ☐ Yes ☐ No ☐ Unknown Date _____

MEDICATIONS TAKEN WITHIN THE PAST 5 YEARS: (check all that apply)

☐ Systemic corticosteroids Dates_____
☐ Cytotoxic chemotherapy/other immunosuppressive therapy Dates_____
☐ Hepatitis B vaccine Dates_____
☐ Hepatitis B immune globulin Dates_____
☐ Immune serum globulin Dates_____

VIII-7

This report is authorized by law (Public Health Service Act, 42 USC 241). While your response is voluntary, your cooperation is necessary for the understanding and control of the disease.

OMB APPROVED
#0920-0131

EXPOSURE INFORMATION

OCCUPATION:

- ☐ Attending physician
- ☐ Nurse/LPN
- ☐ House officer
- ☐ Medical student
- ☐ Phlebotomist/IV team
- ☐ Laboratory worker
- ☐ Housekeeping/Maintenance
- ☐ Other (Specify)_____

LENGTH OF EMPLOYMENT: ☐☐ Years

NAME OF AIDS PATIENT TO WHOM EXPOSURE OCCURRED: _____

Has AIDS patient been reported to CDC? ☐ Yes ☐ No ☐ Unknown Date of Report ___ ___ Month Year

CDC Case Number of AIDS patient (if known) ☐☐☐☐☐

DATE OF EXPOSURE: ☐☐ Month ☐☐ Day ☐☐ Year

LOCATION WHERE EXPOSURE TOOK PLACE:

- ☐ Hospital room/ward
- ☐ Emergency room
- ☐ Laboratory
- ☐ Intensive care unit
- ☐ Operating room
- ☐ Other (specify) _____

TYPE OF EXPOSURE (check all that apply)

- ☐ Needlestick
- ☐ Contamination of an open wound
- ☐ Splash in the eye
- ☐ Scalpel or other instrument
- ☐ Ingestion of blood
- ☐ Other (specify) _____

If exposure to needle or instrument, what was its use in the AIDS patient? _____

Was the needle or instrument visibly contaminated with blood? ☐ Yes ☐ No ☐ Unknown

DESCRIPTION OF THE CIRCUMSTANCES OF THE EXPOSURE _____

_____

_____

TREATMENT OR PROPHYLAXIS GIVEN POST-EXPOSURE:

- ☐ Hepatitis B immune globulin
- ☐ Immune serum globulin
- ☐ Tetanus toxoid
- ☐ Other (specify) _____

WERE ISOLATION PRECAUTIONS USED WHEN CARING FOR THE AIDS PATIENT? ☐ Yes ☐ No

Type of precautions used (check all that apply):

- ☐ Gloves for any type of care
- ☐ Masks
- ☐ Private room
- ☐ Gloves for blood exposure only
- ☐ Gowns
- ☐ Other (specify) _____

RECENT MEDICAL HISTORY

DATE Month Day Year

In the past 6 months, have any of these signs or symptoms been present as a chronic or persistent problem for at least 1 month? (check all that apply)

- ☐ Fever
- ☐ Night sweats
- ☐ Malaise/fatigue
- ☐ Chronic lymphadenopathy, ≥ 3 non-contiguous sites
- ☐ Arthralgias/myalgias
- ☐ Weight loss, unexpected, ≥ 15 pounds or ≥ 10% normal body weight
- ☐ Chronic diarrhea ☐ No pathogen/cause identified ☐ Specific pathogen/cause identified
- ☐ Persistent bone marrow dysfunction ☐ Leukopenia ☐ Lymphopenia ☐ Thrombocytopenia
- ☐ Cough/Shortness of breath
- ☐ Other (specify) _____
- ☐ None of above

RECENT BIRTHS

Is the employee the natural parent of a child born within the past 6 months? ☐ Yes ☐ No
If yes, give date of birth. _____

PHYSICAL EXAMINATION

DATE Month Day Year

Weight in pounds _____

Lymphadenopathy ☐ Yes ☐ No
Location: ☐ Cervical ☐ Supraclavicular ☐ Axillary ☐ Epitrochlear ☐ Inguinal ☐ Other

Oral thrush ☐ Yes ☐ No

Hepatomegaly ☐ Yes ☐ No

Splenomegaly ☐ Yes ☐ No

Other mucocutaneous ulceration ☐ Yes ☐ No

Location: ☐ Oral cavity ☐ Pharynx ☐ Genitalia

Skin Lesions ☐ Yes ☐ No

Location: _____

Description: _____

_____

_____

Other Abnormalities: ☐ Yes ☐ No

Description _____

_____

_____

_____

LABORATORY EXAMINATION

Chest X-ray ☐ Normal ☐ Abnormal (describe) _____ Date of X-ray Month Year

Skin Tests: mm. induration Date of Test Month Year

PPD		___	___
Mumps		___	___
Candida		___	___
SK/SD		___	___
Other (specify _____)		___	___

White Blood Cell Count [ ][ ][ ][ ][ ]

Percentage Lymphocytes [ ][ ][.] %

Platelet Count (Lowest value) [ ][ ][ ][ ][ ][ ]

Date of Tests Month Day Year

T-lymphocyte Subset Counts: Check if T-cell studies not done ☐

	Percentage of Lymphocytes		Percentage of Lymphocytes	Date of T-lymphocyte Tests
T-HELPER (OKT-4, Leu-3)	[ ][ ] %	T-SUPPRESSOR (OKT-8, Leu-2)	[ ][ ] %	Month Day Year

T-HELPER/T-SUPPRESSOR (T_H/T_S) RATIO [ ][.][ ]

Interpretation of T_H/T_S ratio for this patient is: ☐ Normal ☐ High ☐ Low

Range of normal values for T_H/T_S ratio at this laboratory: High normal ___ . Low normal ___ .

SPECIMENS SUBMITTED TO CDC

Serum ☐ Yes ☐ No Whole blood for T-cell studies ☐ Yes ☐ No

ADDITIONAL INFORMATION OR COMMENTS:

_____

_____

_____

_____

_____

INFORMATION SOURCES

1. Name of person completing this form _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

2. Person reporting this case (if different from above) _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

Physician to contact to update information about this patient (if different from above):

3. Name: _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

QUESTIONNAIRE 2

Case Report Number ☐☐☐ Center Number ☐☐

Certain groups of people seem to be at increased risk of developing AIDS. The following questions will help determine what risk factors may be involved. Answering these questions is not required; however, the answers will be helpful in the investigation of this new disease. Your follow-up care will not be affected by your decision to answer or not to answer these questions. Your answers will be kept confidential by the CDC. The CDC will identify your answers only by the number that appears at the top of this page. You should not write your name on this page.

If you chose not to answer these questions, please indicate by checking this box: ☐

After you complete the questionnaire, please place it in the envelope provided and mail it.

Sex: ☐ Male ☐ Female

Marital Status: ☐ Never married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

What was your living arrangement during the last 1 year? (check all boxes that apply)

☐ Alone ☐ With spouse ☐ With children
☐ With male companion(s) ☐ With female companion(s)
☐ Other (please specify _____)

What is your sexual orientation?

☐ Heterosexual ☐ Homosexual ☐ Bisexual
☐ None ☐ Unknown

In the past 5 years, with whom have you had sexual relations?

☐ Male partner ☐ Female partner
☐ Both male and female partners ☐ No sexual relations

Have you ever used needles for self-injection of illicit drugs?

☐ Yes ☐ No

In the past 5 years, have you ever been in jail or served a prison term?

☐ Yes ☐ No

Thank you for your cooperation.

This report is authorized by law (Public Health Service Act, 42 USC 241). While your response is voluntary, your cooperation is necessary for the understanding and control of the disease.

OMB APPROVED
#0920-0131

APPENDIX E

PERSONNEL EXPOSURE FOLLOW-UP FORM

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

RECENT MEDICAL HISTORY

DATE Month ____ Day ____ Year ____

In the past 6 months, have any of these signs or symptoms been present as a chronic or persistent problem for at least 1 month? (check all that apply)

- ☐ Fever
- ☐ Night sweats
- ☐ Malaise/fatigue
- ☐ Chronic lymphadenopathy, ≥ 3 non-contiguous sites
- ☐ Arthralgias/myalgias
- ☐ Weight loss, unexpected, ≥ 15 pounds or ≥ 10% normal body weight
- ☐ Chronic diarrhea ☐ No pathogen/cause identified ☐ Specific pathogen/cause identified
- ☐ Persistent bone marrow dysfunction ☐ Leukopenia ☐ Lymphopenia ☐ Thrombocytopenia
- ☐ Cough/Shortness of breath
- ☐ Other (specify) _____
- ☐ None of above

RECENT BIRTHS

Is the employee the natural parent of a child born within the past 6 months? ☐ Yes ☐ No
If yes, give date of birth. _____

PHYSICAL EXAMINATION

DATE Month ____ Day ____ Year ____

Weight in pounds _____

Lymphadenopathy ☐ Yes ☐ No
Location: ☐ Cervical ☐ Axillary ☐ Inguinal
☐ Supraclavicular ☐ Epitrochlear ☐ Other

Oral thrush ☐ Yes ☐ No

Hepatomegaly ☐ Yes ☐ No

Splenomegaly ☐ Yes ☐ No

Other mucocutaneous ulceration ☐ Yes ☐ No

Location: ☐ Oral cavity ☐ Pharynx ☐ Genitalia

Skin Lesions ☐ Yes ☐ No

Location: _____

Description: _____

_____

_____

Other Abnormalities: ☐ Yes ☐ No

Description _____

This report is authorized by law (Public Health Service Act, 42 USC 241). While your response is voluntary, your cooperation is necessary for the understanding and control of the disease.

OMB APPROVED
#0920-0131

LABORATORY EXAMINATION

Chest X-ray ☐ Normal ☐ Not done ☐ Abnormal (describe) _____ Date of X-ray Month Year

Skin Tests: mm. induration — Date of Test Month Year — Not done ☐

	mm. induration	Date of Test Month	Year
PPD			
Mumps			
Candida			
SK/SD			
Other			

White Blood Cell Count _____ Percent Lymphocytes _____ % Platelet Count (Lowest value) _____ Date of Tests Month Year Not done ☐

T-lymphocyte Subset Counts: Check if T-cell studies not done ☐

	Percentage of Lymphocytes		Percentage of Lymphocytes	Date of T-lymphocyte Tests Month	Year
T-HELPER (OKT-4, Leu-3)	___ %	T-SUPPRESSOR (OKT-8, Leu-2)	___ %		

T-HELPER/T-SUPPRESSOR (T_H/T_S) RATIO ___.___

Interpretation of T_H/T_S ratio for this patient is: ☐ Normal ☐ High ☐ Low

Range of normal values for T_H/T_S ratio at this laboratory: High normal ___.___ Low normal ___.___

SPECIMENS SUBMITTED TO CDC

Serum ☐ Yes ☐ No Whole blood for T-cell studies ☐ Yes ☐ No

ADDITIONAL INFORMATION OR COMMENTS:

_____

_____

_____

_____

_____

INFORMATION SOURCES

1. Name of person completing this form _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

2. Person reporting this case (if different from above) _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

Physician to contact to update information about this patient (if different from above):

3. Name: _____ Telephone ( ) _____ Ext _____

   Title/Position/Specialty _____

   Institution/Address _____

Guide to chemical agents for disinfection and/or sterilization

Products Accepted	Chemical Classification	Disinfectant	Sterilant
ProMed Brand Wescodyne-D	Iodophors, 1% available iodine	Diluted according to manufacturer's instructions, 10 minutes	—
Biocide			
Household Bleach	Sodium hypoclorite	Diluted 1:5 to 1:100, 10 to 30 minutes	—
Omni II	o-phenylphenol 9.0% and o-benzyl-p-chlorophenol, 1.0%	Diluted 1 in 32, 10 minutes at room temperature	—
Sporicidin	Glutaraldehyde 2% alkaline with phenolic bufer	Diluted 1 in 16, 10 minutes at room temperature	Full strength, 6¾ hours at room temperature
Glutarex	Glutaraldehyde 2% neutral	Full strength, 10 minutes at room temperature	Full strength, 10 hours at room temperature
Banicide Sterall Wavicide 01	Glutaraldehyde 2% acidic potentia-ed with non-ionic ethoxylates of linear alcohols	Diluted 1 in 2, 10 minutes at room temperature	Full Strength, 1 hour at 60°C; 4 hours at 40 to 50°C; 10 hours at room temperature
Exspor	Chlorine dioxide	2 minutes at room temperature	6 hours at room temperature
Centra* Cidex 7 CoeCide K-Cide 10* Maxicide* Omnicide ProCide* Saslow Professional* Sporex Steril-Ize Vitacide	Glutaraldehyde 2% alkaline	Full strength, 10 minutes at room temperature	Full strength, 10 hours at room temperature

*Available in regular (14 day activity) or long life (28 day activity)

Mitchell, Edgar W., "Chemical Disinfecting/Sterilizing Agents," California Dental Association Journal, October, 1985, page 65.

Disinfectant characteristics of iodophors

Positive

1. EPA - licensed surface disinfectant.
2. Broad spectrum disinfectant - especially effective against heavy viral contamination.
3. Biocidal activity occurs within approximately 30 minutes.
4. Economical, relatively inexpensive.
5. More effective in dilute solution than in concentrate.
6. Solutions are easily mixed with water for dilution.
7. Produce few, if any, physical side reactions - less allergenic than tincture of iodine.
8. Solutions have built-in color indicator that changes when iodophor molecules are exhausted. Change of solution is indicated when amber color disappears.
9. Very highly recommended and very effective as a hard-surface disinfectant.
10. When used in conjunction with a thorough cleansing procedure, surface disinfection occurs within 3 to 30 minutes depending on the amount of debris and virus present.
11. Surfactant carrier in solutions helps to maintain surface moistness and to protect the iodophor during its action. Residual biocidal action on hard surfaces may continue for some time after surface appears dry.
12. Some dental literature indicates that mixing alcohol with certain iodophor solutions provides an effective surface disinfectant.

Negative

1. Solutions are not classified as a sterilant. They are to be used solely as a disinfectant in conjunction with a total aseptic program.
2. Solution somewhat unstable - in particular at high temperatures.
3. Manufacturer's dilution and contact time recommendations must be strictly followed.
4. Solution loses activity with age.
5. Sporicidal activity requires prolonged exposure.
6. Solution may temporarily discolor some light colored surfaces with repeated use over prolonged periods.
7. Corrosive to some metals.
8. Inactivated by hard water.
9. Diluted iodophors may be inactivated by addition of alcohol.

Adapted and reprinted with permission of *Dental Products Report*, copyright 1985.

Molinari, John A., "Surface Disinfection and Disinfectants," California Dental Association Journal, October, 1985, page 78.

APPENDIX H

HUMAN-T-LYMPHOTROPIC VIRUS-III TEST REPORT
MONTANA STATE DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES
SEXUALLY TRANSMITTED DISEASES CONTROL PROGRAM

To be submitted within 15 days after the last day of each month.

Please fill in blanks:

Date of report: month _____ day _____ year _____

Report for the previous month of _____

Name of reporting laboratory or physician: _____

Telephone number of reporter: _____

Total number of negative HTLV-III antibody tests done during previous month ____

A. Number of ELISA tests done _____

B. Number of Western Blot tests done _____

C. Number of any other
(please specify type of) tests done _____

Signature of reporter: _____

Submit to: STD Control Program
MT. Dept. of Health & Env. Sciences
Cogswell Building
Helena, MT 59620

JG/vb-95a

CONFIDENTIAL CASE REPORT CARD
for
HTLV-III Positive Test

Patients Initials: _____

Date Test Performed: _____

Name of Reporter: _____

Address of Reporter: _____
(City)

JG/vb-94a
11/85

MONTANA CODE ANNOTATED, 1985

Part 3

Confidentiality of Health Care Information

Part Cross-References
Right of privacy guaranteed, Art. II, sec. 10, Mont. Const.

50-16-301. Purpose. The purpose of this part is to establish safeguards for maintaining the integrity of confidential heaith care information.
History: En. Sec. 1, Ch. 578, L. 1979.

50-16-302. Definitions. As used in this part, the following definitions apply:

(1) "Health care provider" means a person, corporation, facility, or institution licensed by this state to provide health care services.

(2) "Health care services" means diagnosis, treatment, medical evaluation, advice, or other activities permitted under the health care licensing statutes of this state.

(3) "Confidential health care information" means information obtained by a health care provider relating to health care history, diagnosis, condition, treatment, or evaluation.

(4) "Peer review committee" means a committee of a state or local professional medical society or of a medical staff of a licensed hospital or other health care facility that is operated pursuant to written bylaws approved by the governing board of the hospital or other health care facility or approved by an organization of health care providers and formed pursuant to state or federal law and authorized by law to evaluate health care services.

(5) "Third party" means a person or entity other than the person to whom the confidential health care information relates and other than a health care provider.

(6) "Qualified person" means a person whose training and experience is appropriate to the nature and level of work in which he is engaged and who, when working as part of an organization, is performing the work with published and adequate administrative safeguards against unauthorized disclosures.

(7) "Administration" includes but is not limited to accreditation, reimbursement, liability risk management, appraisal, and defense or prosecution of legal actions.
History: En. Sec. 2, Ch. 578, L. 1979.

50-16-303. No limitation on licensing boards. This part does not limit the authority, otherwise provided by law, of a licensing or disciplinary board of this state to require a peer review committee to report to it concerning any disciplinary actions or recommendations of the committee or to transfer to it records of the committee's proceedings or actions, including confidential information. This part does not limit the authority of such board to restrict or revoke a license to practice. However, personally identifiable portions of a person's confidential health care information may not be used in any legal action without the written consent of the person or his authorized representative, except upon court order.
History: En. Sec. 6, Ch. 578, L. 1979.

50-16-304. Reporting obligations not limited. This part may not be construed to limit the reporting obligations provided by Title 37, chapter 3, part 4, or any other statute which requires information to be reported to a government agency.

History: En. Sec. 8, Ch. 578, L. 1979.

50-16-305. No disciplinary or punitive action for disclosing violation. No disciplinary or punitive action may be taken against an employee or agent who brings evidence of violation of this part to the attention of a person or entity.

History: En. Sec. 7, Ch. 578, L. 1979.

50-16-306 through 50-16-310 reserved.

50-16-311. When consent is required to release or transfer confidential health care information. (1) Except as provided in subsection (2) or as otherwise specifically provided by law or the Montana Rules of Civil Procedure, confidential health care information relating to a person may not be released or transferred without the written consent of the person or his authorized representative.

(2) Consent is not required for release or transfer of confidential health care information:

(a) to a physician, dentist, or other medical person for diagnosis or treatment of an individual in a medical or dental emergency;

(b) to a peer review committee if the information concerns matters within the scope of the licensed professional practice of the committee members;

(c) to qualified persons for the purpose of conducting scientific research, management audits, financial audits, program evaluations, or similar studies. However, qualified persons may not directly or indirectly identify an individual patient in a research report, audit, or evaluation or disclose a patient's identity in any manner.

(d) to a health care provider:

(i) as may be reasonably necessary to provide health care services to the individual about whom the information relates; or

(ii) in the administration of the office, practice, or operation in connection with the providing of health care services to the individual about whom the information relates;

(e) to an employer as may be reasonably necessary in the administration of a group insurance plan or to a workers' compensation insurer, the division of workers' compensation, or the workers' compensation judge, as is necessary in the administration of Title 39, chapters 71 and 72;

(f) when a person's insurance coverage obligates more than one insurer with respect to a claim or benefit;

(g) to a state insurance department for the purpose of reviewing an insurance claim or complaint made to such department by an insured or his authorized representative or by a beneficiary or his authorized representative of a deceased insured;

(h) to a law enforcement officer about the general physical condition of a person being treated in a health care facility if such person was injured on a public roadway or was injured by the possible criminal act of another;

(i) to the news media about the general physical condition of an injured person being treated in a health care facility, provided the existence of the hospitalization is publicly known.

(3) For the purpose of this section, the term "general physical condition" is limited to a description of the condition as "satisfactory", "serious", or "critical".

History: En. Sec. 3, Ch. 578, L. 1979; amd. Sec. 1, Ch. 725, L. 1985.

Compiler's Comments

1985 Amendment: Inserted (2)(h), (2)(i), and (3).

50-16-312. Disclosure by third party to physician of person affected. (1) A third party who has performed an adverse action defined in subsection (2) may transfer confidential health care information to a designated physician when the third party receives a written request signed by the affected person or his authorized representative.

(2) The adverse action referred to in subsection (1) may include but is not limited to:

(a) denial of an application for an insurance policy;

(b) issuance of an insurance policy with other than standard and uniform restrictions;

(c) rejection in whole or in part of any claim for insurance benefits;

(d) denial of an employment application or termination of employment when such denial or termination is for health reasons.

(3) Prior to making a transfer, a third party may require payment of actual expenses incurred in the retrieval, duplication, and forwarding of such information.

(4) A physician receiving confidential health care information pursuant to subsection (1) may review and interpret the information. Thereafter, the physician may, in his discretion, disclose to the affected person as much of the transferred information as he believes is in the best interest of the affected person to know.

History: En. Sec. 4, Ch. 578, L. 1979.

50-16-313. Rights of person affected regarding modifications and additions. (1) After reviewing confidential health care information received pursuant to 50-16-312(4), an affected person or his authorized representative may request a third party to amend or expunge any part of the information that he believes is in error or request the addition of relevant information. Upon receiving such a request, the third party shall notify the health care provider who initially forwarded the information to the third party. If the health care provider concurs with the modification requested by the affected person, the third party shall modify the information in accordance with the request.

(2) Modification of confidential health care information may be required by court order upon action brought by the requestor.

(3) After reviewing confidential health care information received pursuant to 50-16-312(4), a person has the right to place into the confidential file a personal statement of reasonable length regarding the correctness or relevance of existing information or regarding the addition of new information. The statement or a copy thereof shall at all times accompany that part of the information to which it relates.

History: En. Sec. 4, Ch. 578, L. 1979.

50-16-314. Privileged information — exemption from compulsory legal process. (1) Except as provided in subsection (2), confidential health care information is not subject to compulsory legal process in any type of proceeding, including any pretrial or other preliminary proceedings, and a person or his authorized representative may refuse to disclose and may prevent a witness from disclosing confidential health care information in any proceeding.

(2) The exemption or privilege provided in subsection (1) does not apply:

(a) when the individual's physical or mental condition is relevant regarding the execution or witnessing of a will or other document;

(b) when the physical or mental condition of an individual is introduced by a party claiming or defending as a successor or beneficiary of the individual;

(c) when an individual makes communications to a psychiatrist in the course of a court-ordered psychiatric examination after having been informed that the communications are admissible only as to issues involving the individual's mental condition;

(d) when required by Rule 35, M.R.Civ.P., or otherwise ordered by a court.

History: En. Sec. 5, Ch. 578, L. 1979.

APPENDIX J

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

EMERGENCY AMENDMENT OF RULES
16.28.201 AND 16.28.202

1. Statement of reasons for emergency: Acquired immune deficiency syndrome (AIDS) is emerging as one of this country's most profound public health threats. As yet, there is no cure for those who develop AIDS and it is ultimately fatal in all cases. Development of a cure for the disease and minimization of its spread while the search for a cure continues requires nationwide collection of data from those who develop AIDS (medical history, life style, age, sex, etc.) and those who have been exposed to the virus. A large body of knowledge on the subject has already been developed, but the search for more definitive information must continue. Montana does not currently include AIDS or exposure to the AIDS-causing virus in the list of communicable diseases which must be reported to public health authorities, meaning that the department cannot collect the Montana data needed to help develop adequate control measures. The emergency rules add both conditions to the list of reportable diseases, specify the type of information to be reported, require the reports to be submitted by any physician or laboratory either diagnosing AIDS or performing a test to determine whether a person has been exposed to the AIDS-causing virus, and require confirmation of the test or diagnosis by the department's laboratory.

The department is presently working on a complete revision of the communicable disease rules, including AIDS control and reporting measures, but needs to have AIDS-related information reported in the interim in order to ascertain the degree of threat the disease currently represents in Montana and to contribute to the nation-wide data collection necessary for development of adequate control measures. Consequently, the department adopts these emergency rules pending adoption of permanent rules. They will be effective immediately upon filing with the Secretary of State.

2. The emergency rules amend 16.28.201 and 16.28.202 and provide as follows:

16.28.201 REPORTERS (1) A person, including but not limited to a physician, dentist, nurse, medical examiner, other practitioner, administrator of a health care facility, public school superintendent, or headmaster or administrator of a private school, who knows or has reason to believe that a category A, B, C, or D reportable disease, as specified in 16.28.202, exists shall report as required in ARM 16.28.202 to a local health officer or the department.

(2) A person administering a clinical laboratory in which a laboratory examination of any specimen derived from the human body yields microscopic, cultural, immunological,

serological, or other evidence indicative of a disease listed in subsection (2)(c) of this rule shall notify the local health department or the department.

(a) A notification must include the name, date and result of the test performed; the name and age of the person from whom the specimen was obtained; and the name and address of the physician for whom the test was performed. Notification may be by telephone, submission of a legible copy of the laboratory report, or submission of a department reporting form which may be obtained from the Preventive Health Services Bureau.

(b) A laboratory notification submitted in accordance with this rule is confidential and is not open to public inspection.

(c) The diseases subject to notification under subsection (2) of this rule are:

Brucella
Chancroid
Diphtheria
Gonorrhea
Granuloma inguinale
Hepatitis A or B
Leptospirosis
Lymphogranuloma venereum
Rubella (non-immune persons only)
Salmonellosis
Shigellosis
Syphilis
Tuberculosis
Typhoid or Paratyphoid Fever or any other disease listed in ARM 16.28.202(1) through (4).

(3) A physician who diagnoses a case of acquired immune deficiency syndrome (AIDS) must submit to the department and the local health officer the report required by 16.28.202(5)(c).

(4) A physician or laboratory performing a blood test which shows the presence of the antibody to the human T-lymphotropic virus type III must:

(a) Submit to the department the report required by 16.28.202(5)(d); and

(b) Obtain, if possible, and submit to the department laboratory a second blood specimen in order to confirm the test results.

(5) The administrator of a laboratory in which a test of blood is made to determine whether the antibody to the human T-lymphotropic virus type III is present must submit to the department by the 15th day following the month in which the test was performed a report on a form supplied by the department indicating the number of tests with negative results for

that antibody which were done during that month.
AUTHORITY: 50-1-202, 50-17-103, 50-18-105 MCA
IMPLEMENTING: Sec. 50-1-202, 50-2-118, 50-17-103, 50-18-102, 50-18-106 MCA

16.28.202 REPORTABLE DISEASES Reportable communicable diseases include:

(1) - (4) Same as existing rule.

(5)(a) Category E diseases and conditions are:

(i) Acquired immune deficiency syndrome (AIDS)

(ii) Potential AIDS, as indicated by the presence of the human T-lymphotropic virus type III antibody.

(b) A category E disease or condition must be reported to the department and, in the case of AIDS, the local health officer of the county from which the report is made by 5:00 p.m. Friday of the week in which the diagnosis of AIDS is made or the test showing potential AIDS is performed.

(c) The report for AIDS must include the information required by the department's communicable disease confidential case report form available from the department.

(d) The report of potential AIDS must include:

(i) the date the test identifying the antibody was performed;

(ii) the name and address of the reporter; and

(iii) the initials of the person tested.

(e) The name of any category E case and the name and street address of the reporter of any such case are confidential and not open to public inspection.

AUTHORITY: Sec. 50-1-202, 50-17-103, 50-18-105, 50-18-106 MCA
IMPLEMENTING: Sec. 50-1-202, 50-2-118, 50-17-103, 50-18-102, 50-18-106 MCA

3. The foregoing amendments are effective November 4, 1985.

JOHN J. DRYNAN, M.D., Director

Certified to the Secretary of State November 4, 1985